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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the nounce after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should
be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: if Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH DIANE SUSAN PARMER 8:05 NOVEMBER 1995 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. lest birthday) 7. DATE OF BIRTH (Month, Day, Year) MCLY 18,194 IF UNDER 1 YEAR 8. BIRTHPLACE (State or Foreign Country) 1 | M 2 | F DAYE 151-32-272 54 MARYLAND 96. CITY, TOWN OR LOCATION OF DEATH TOWSON 9a, FACILITY NAME (If not institution, give street and number) BALTIMORE GREATER BALTIMORE MEDICAL CENTER DIRECTOR RESIDENCE OF DECEDENT 10e STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY BALTIMORE MD COCKEYSVIlle 1 YES 2 NAO FUNERAL 10a. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? Valley 21030 USA 12. WAS DECEDENT EVER IN U.S. ADMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—II yes, specify Guban, Mexican, Puerto Rican, etc.)
1 YES 2 N NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married BY 3 Widowed 4 Divorced WHITE COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only high MARRIOTT CORP. mentary/Secondary (0-12) College (1-4 or 5+) 12 WAITRESS 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) ANTHONY MARINO KATHERINE BE IZORIA 19a. INFORMANT'S NAME (Tipo Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Cockeysville, Md 21030 Bradley 350 Ringold Valley Cir YARMEY 20a METHOD OF DISPOSITION
1 © Burial 2 Cremation 3 Ram 206. PLACE AND DATE OF DISPOSITION (Name of Campetery, crematory or other place)

DULANEY VALLEY MEM Gardens

DATE 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State Timonium, Md. 4 Donation 5 Other (Specify) . 21. SIGNATURE OF FUNERAL SERVICE LICENSE 22. NAME AND ADDRESS OF FACILITY OS CHIMES EVANS CHAPEL OF CHIMES 2325 YORK Rd. TIMONIUM, Md. 21093 Coest 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, Approximata ahock, or heart fellure. List only one cause on each line Interval Between IMMEDIATE CAUSE (Final Onset and Dasth disease or condition_ mos resulting in death) DUE TO (OR AS A FONSEQUENCE OF): CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause, Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initieted events resulting in death) LAST PART II. Other algnificent conditions contributing to deeth but not resulting in the underlying ceuse given in Part i. 24a. WAS AN AUTOPSY MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? PERFORMED? metastasi 1 YES 2 1 TYES 2 T NO PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES INO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL OTHER: 1 TES 2 NO Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) 26c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED Netural м 1 YES 2 NO BY Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 4 Homicide 1 DEERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(e) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the ceuse(a) and manner ee stated, 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE aus



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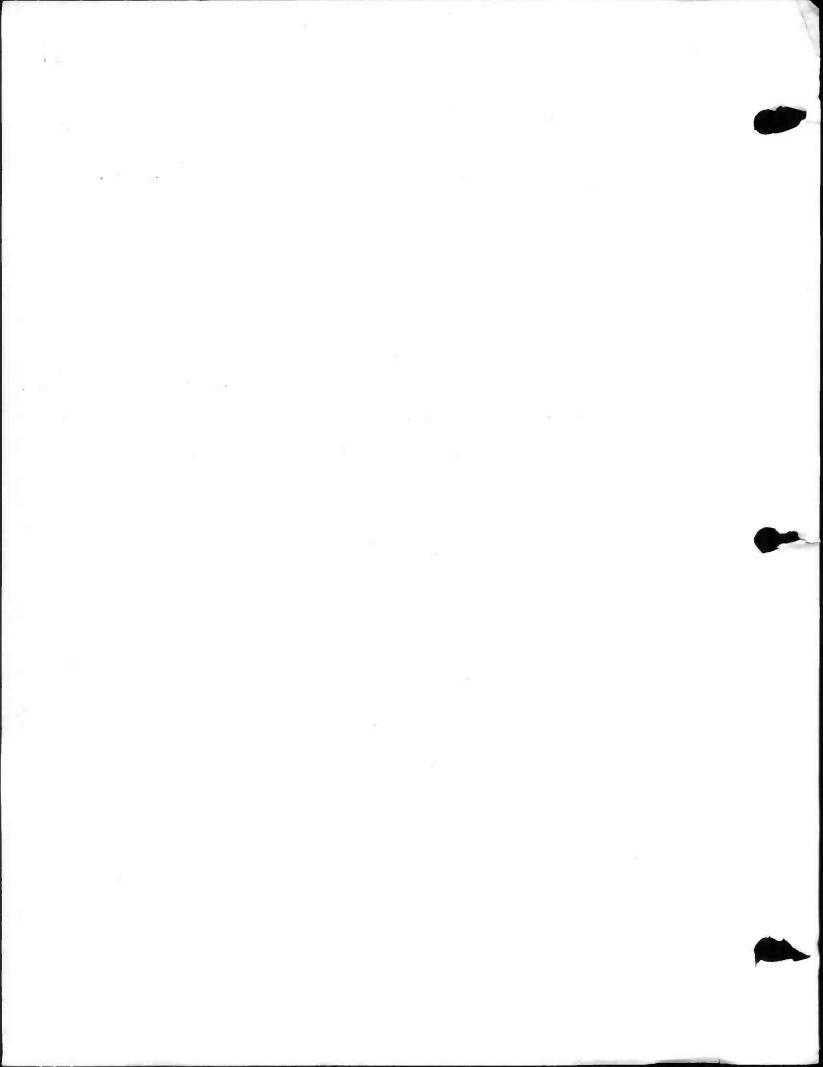
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31. DATE FILED (Month,

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

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TO BE COMPLETED BY FUNERAL DIRECTOR

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2	Page	Line
) THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with 4 hours after death. Page 6	
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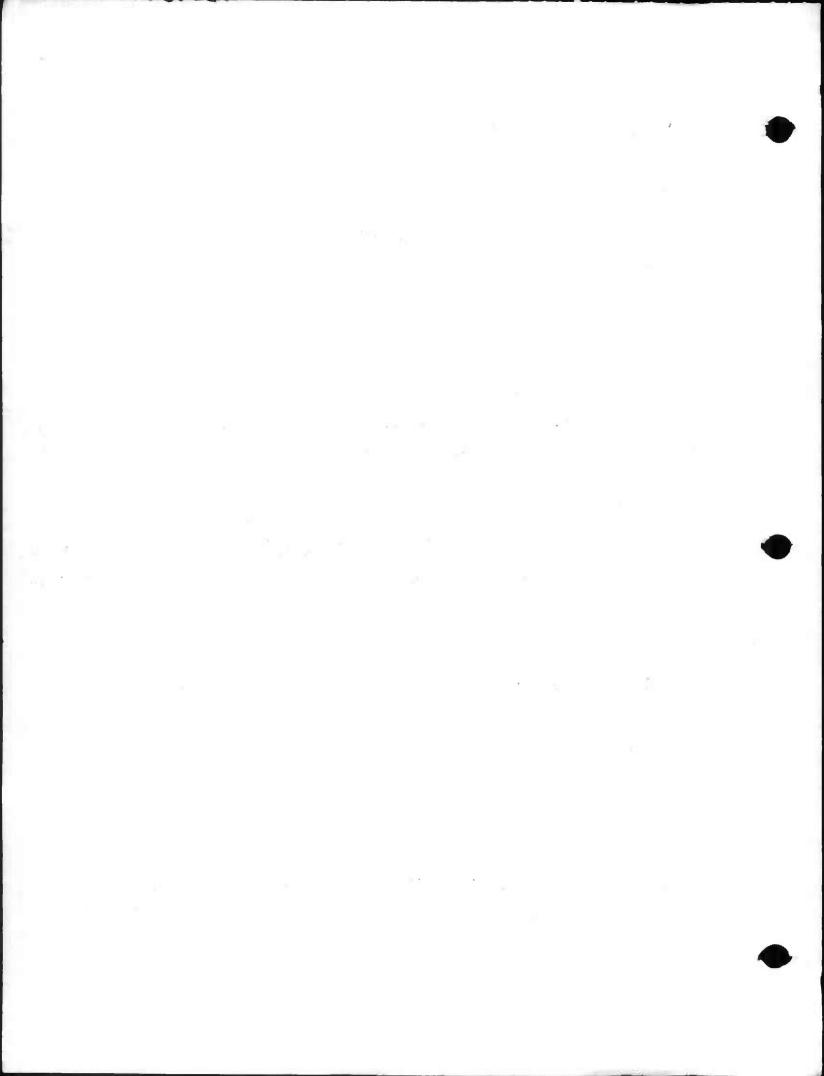
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

beath. Page 6 may be retained by the hospital or attending physician.

Veneral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should TO THE HOSPITAL OR ATTENDING PHYSICIAN: The raw requires use use use constitution and completely filled in by the funeral director, page 5 shours be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once, important.

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FOR STATE REGISTRAR		STATE OF N	IARYLAN		RTMENT O		ALTH AND	MENTAL				
1. DECEDENT'S NAME (First	Mickella I ant)			CERTII	TOATE	OF I	DEATH	2 DATE	REG. NO.			3. TIME OF DEATH
Tren	9	Pot	ts					NONTH	RMB	53	995	2:12 0 "
4. SOCIAL SECURITY NUMBER 215-24-447		5. SEX		rs. lest birthday) 75 YRS.		_	HOURS MIN.	7. DATE ((Month)	Dey, 160r)	99	Countr	PLACE (State or Foligin
9a. FACILITY NAME (If not in		treet and number)			9b. CITY, TO	OWN OR	LOCATION OF D		00,20	_	UNTY OF D	
SINAI HOSI					BA	LTI	MORE				N/A	773
10e. STATE	10b. COUNT	1		10c, Cl	TY, TOWN OR I	LOCATIO	ON					10d. INSIDE CITY
MARYLAND	BALT	IMORE		В	ALTIMO	RE						1 TES 2 X NO
10e. STREET AND NUMBER						101.	ZIP CODE			10g. Cl	TIZEN OF W	WHAT COUNTRY?
4204 OLD 1	MILFOR						21208				U.S	S.A.
11. MARITAL STATUS 1 Never Married 2	Mandad	12. WAS DECEDEN FORCES? 1	T EVER IN U.	S. ARMED			NDENT OF HISPAI			or No—	14. RACE Black	— American Indian, t, White, atc.
3 N Widowed 4 Dive		IF YES, GIVE W	AR OR DATE	SA			2 XNO Specif				Speci	WHITE
	EDENT'S EDU ly highest grade		16	Give kind of	work done duri			16b.	KIND OF BU	SINESS/IN	IDUSTRY	
Elementary/Secondary (0-12)	College (1-4 or 5)	HOUSE					OWI	N HO	ME	
17. FATHER'S NAME (First, M	ficiale, Last)						18. MOTHER'S NA	ME (First, M		Sumame)		
HENRY		WEIL						ETTIE				GREEN
190. INFORMANT'S NAME (MANI					Number or Rural					MARYLAND
20a, METHOD OF DISPOSIT	TION			ACE AND DATE	OF DISPOSITIO	ON (Nerr	ne of	OATE	20c. LO	CATION -	- City or To	wn, State
1 X Burial 2 Crematic 4 Donation 6 Donation		oval from State	- BET	ry cremetory or TFIL	other place) OH CON	G.		11/6/	95 B	ALTI	MORE,	MD.
21. SIGNATURE OF TUNERA	AL SERVICE LI	ENSER	,		22. NA	ME AND	ADDRESS OF FA	CILITY				
> Wax		Tours					EVINSON					01015
23. PART I. Smar the district, or his immediate cause (Fi disease or condition	naert fsilure.	complications the	t caused ti se on esc	ha death. Do h line.	not enter th	e mod		ch aa card	liac or reap			Approximate interval Between Onset and Dasth
resulting in deeth)	→	e. DUE TO	COLT	ONSEQUENCE (OF):		farct	TOV	1			IN NOW
Sequentially list condi- if any, leeding to imme cause. Enter UNDERLY CAUSE (Disease or inj- that initiated events resulting in death) LAS	ring ury	С		ONSEQUENCE (2 days
PART ii. Other signific	ent condition	ne contributing to	deeth but	not reculting	in the unde	rlying	cause given in	Part i.	24s. WAS AN		r 24b	WERE AUTOPSY FINDINGS
Arterio	scle	rotico	arg	lio uc	115 CU	lar	dise	J26	PERFO	nd.		AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
DID TOBACCO U	JSE CONT	RIBUTE TO CA	USE OF	DEATH Y	ES NO	D 区	UNCERTAI	N				
25. WAS CASE REFERRED 'EXAMINER?	TO MEDICAL	HOSPITAL:	26.	PLACE OF OE	OTHER:	y one)						
1 TYES 2 NO		1 Inpetient 2			4 Nursing	g Home	5 🗆 Rasidenca					
	Pending Investigation	28a. DATE OF (Month, E		28b. Ti	NJURY	WOR 1 Y		26d. DES	CRIBE HOW	O YRULAI	CCURED	
2 Accident 3 Suicide 8 4 Homicide	Could not be determined	28e. PLACE C building,	F INJURY — atc. (Specify,	At home, farm,	, atreet, factory	, office			ATION (Street or Town, State,		er or Rural I	Route Number,
29a. CERTIFIER												
(Check only		ICIAN: To the best of ER: On the basis of a										a) and manner as stated.
296. SIGNATURE AND TITL	E OF CERTIFIE	R	^	4	, A		29c. LICENSE NU	MBER		29d. D/	ATE SIGNED	(Month, Day, Year)
Jane, a	Files	en MA.	128:	siden	+ Phy	5	0401	02	/	PV	VOL	3,1995
Paul (A S	VPC. V	M DEAT	5 1 1A	D. (tor	aital	. Br	14.	Mr	12	1215
31. DATE FIL NOV 8	71995	32 REGISTA	R'S GIGNAT	Redell			1					



completely filled in by the funeral director, page 5 should be detached for use as the burial-transit

requires that the death certificate be executed within The law n OR ATTENDING PHYSICIAN: THE HOSPITAL (THE FUNERAL C filed within 72 h TO THE HOSPITA
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IMPORTANT: IS

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attending physician and corrected Hygiene prior to burial,

signed by the atter Health and Mental shows any injury,

certificate has been h the State Dept. of

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DIRECTOR: After the hours after death v

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95 33503 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE RAR CERTIFICATE OF DEATH S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH MONTH 995 PARKER 12:16 7. DATE OF BIRTH (Month, Day, Yea 6. AGE (in vrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS 8. BIRTHPLACE (State or Foreign Country) 78 2808 1 X M 2 -DAYS 14 YRS EEB. MARNLAND 9b, CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH BALTIMORE VERSITY HOSPITAL CE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY BALTIMORE LAND 1 YES 2 NO AND NUMBER 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? AVENUE USA. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR OATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify If yes, specify Cuben, Mexican, Puerto Rican, atc.) STATUS 14. RACE — American Indian, Black, White, atc. If yes, specify Cubs arried 2 Married d 4 Divorced 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) /Secondary (0-12) College (1-4 or 5+) GRADE ACKING NAME (First Micidia Last) 18. MOTHER'S NAME (First, ROLAND 19a. INFORMANT'S NAME (Type/Print) AGDALINE MO. 2/2/7 20a METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town. 1 N Buriel 2 Cremation 3 4 Donation 5 Other (Specify) 11-6-95 BALTIMORE, 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY
TOSEPH H, BROWN JR. 19/13W, BALTIMORE ST. BALTO, MD. 21223 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. Liet only one cause on each line. Interval Between IMMEDIATE CAUSE (Final Onset and Death disease or condition_ Preumocystis I week resulting in death) OULTO (OR AS A CONSEQUENCE OF) nodeficiency Syndrome Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in deeth) LAST PART II. Other eignificent conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO oxtimes UNCERTAIN \square 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? HOSPITAL: NO 1 Inpetient 2 - ER/Outpetient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF GEATH 28a. DATE OF INJURY (Month, Day, Year) 26b. TIME OF 28c. INJURY AT WORK? 28d. OESCRIBE HOW INJURY OCCURED 1 Natural 1 YES 2 NO Investigation 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) e Could not be 4 Homicide 29a, CERTIFIER 1 💢 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis tion end/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNEO (Month, Day, Year)

BALTIMORE

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30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print,

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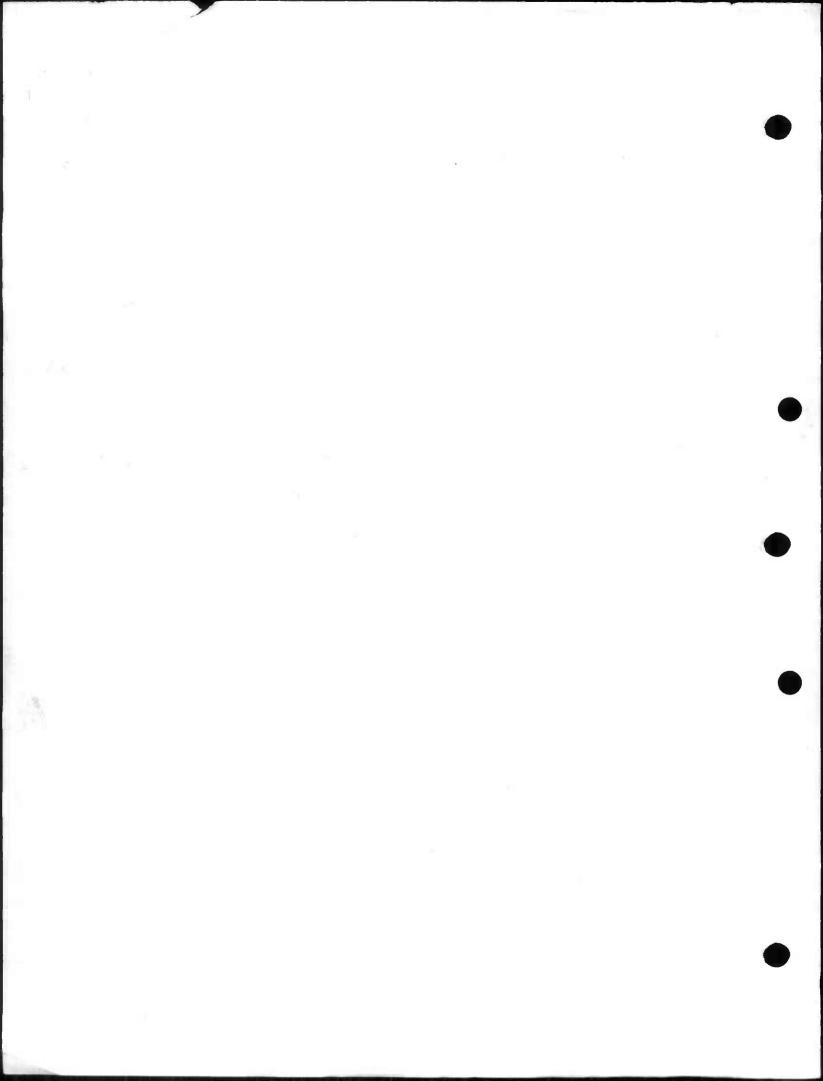
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OHMH-16 Rev 1/89

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within at hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Bages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPARTM CERTIFICA			MENTAL HYGIENE REG. NO.		0000.		
	1. DECEDENT'S NAME (First, Middle, Lest)	IA BRACE,	PA	RKE	ER	2. DATE OF DEATH MONTH OC TO BERCAN	21 9 J	3. TIME OF DEATH 1645 M		
	4. SOCIAL SECURITY NUMBER 214-16-9103 A 9e. FACILITY NAME (If not institution, give sp	5. SEX 6. AGE (1) 1 M 2 W F 75 reet end number)	7. DATE OF BIRTH (Month, Day, Year) MAR, 8, 19 ATN	Co	RTINPLACE (State or Foreign unitry) 5. C., F DEATH					
DIMECTOR	RESIDENCE OF DECEDENT	SPITAL CEN	TER X	ANDA	LLSTOW,	√	BAL	<i>T</i>		
DIME	10e. STATE 10b. COUNTY	NA		WN OR LOCAT	ION			10d. INSIDE CITY LIMITS? 1 YES 2 NO		
MAL	100. STREET AND NUMBER 4501 PENHUR.			-	ZIP CODE 2 / 2 / 5			F WHAT COUNTRY?		
BY FUNERAL	11. MARITAL STATUS 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES	2 PNO	13. WAS DEC			or No — 14. R	ACE — American Indian, lack, White, atc. pecify:		
3	15. DECEDENT'S EDUC (Specify only highest grade	CATION completed)	16a. DECEDENT'S USU (Give kind of work life. Do NOT use ref	done during mo		16b. KIND OF BUS	1	YACK		
COMPLET	Elementery/Secondary (0-12)	College (1-4 or 5+)	LABORE	,		INTER	IOR D	ECORATOR		
	17. FATNER'S NAME (First, Middle, Last)	,				ME (First, Middle, Maiden \$	Sumame)			
O BE	WILLIE BRACEY 190. INFORMANT'S NAME (Type/Print)		19b. MAILING ADO	DRESS (Street e		E WARRE oute Number, City or Yown				
2	WILLIAM BRAG					VE BALT.	mD 2	1205		
	20a. MFTHOD OF DISPOSITION 1	oval from State cem	PLACE AND DATE OF DI etery, cremetory or other p	SPOSITION (No	me of	0ATE 200. LOC	LT. mD			
	THE BIGNATURE OF PUMERAL SERVICE LICE	O Crome	artie	BETT.		ERAL HO		mo 21213		
	11	e. CONGEST	ive He	enter the mo	de of dying, auch	aa cardlec or reapir		Approximate Interval Between Onset and Death		
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initieted events resulting in death) LAST									
MEDICAL C	PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part 1. PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part 1. PERFORMED? 1 YES 2 NO 246. WAS AN AUTOPSY FINDINGS AMAILABLE PRIDE TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO									
PHYSICIAN:	DID TOBACCO USE CONTI		F DEATH YES		UNCERTAIN					
200	EXAMINER?	HOSPITAL: Inpetient 2 ER/Outp		THER: Nursing Nor	e 5 🗆 Raeldence (6 Other (Specify)				
ВУ РН	27. MANNER OF DEATN 1 Netural 5 Pending 2 Accident Investigation	(Month, Day, Year)	28b. TIME OF	28c. INJ W0	RK?	28d. DESCRIBE NOW IN	IJURY OCCURED			
_	3 Suicide 8 Could not be 4 Nomicide determined	28s. PLACE OF INJURY building, atc. (Spec	— At home, ferm, atree	t, factory, office 281. LOCATION (Street end Number or Rural Route Number, City or Town, State)						
COMPLETED	onel /-	CIAN: To the best of my know R: On the basis of exemination						se(e) and menner sa stated.		
<u>и</u>	29b. SIGNATURE AND TITLE OF CERTIFIER	in lw			29c. LICENSE NUM	1333	≥ OC	NED (Month, Day, Year)		
2	30. NAME AND ADDRESS OF PERSON WHI	O COMPLETEO CAUSE OF DE	ATN (ITEM 27) (Type, Prin	0. L	10211	33		,		
	3NOV 0 71995	32. REGISTRAR'S SIGN	ATURE					10		



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examiner must be notified at once.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
al.	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal,
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r death. Page 6 may be retained by the hosp	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the host

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1 -

	1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATN MONTH DAY YEAR O 2.7														
i	Frank Niles Robinson November 5, 1995 8:15												A M		
	4. SOCIAL SECURITY NUMB	BER	5. SEX	6. AGE (In yrs. la	asi birthday)								PLACE (State	or Foreign	
	214-68-448	32	1 🔀 M 2 🗌 F	DAYS	HOURS	MIN.	Feb. 15,1959 Maryland				- 1				
ļ	9s. FACILITY NAME (If not in	stitution, give sti	reet and number)			9b. CITY	r, TOWN	OR LOCATI	ON OF DE				NTY OF O	EATN	
E I	3109 Milfo	ord Ave	nue			В	alti	more				N/	A		
DIRECTOR	RESIDENCE OF DEC				10.00	TOUR.	001001	71011						TOTAL INDICATION	OLEN
뿚	10a. STATE	10b. COUNTY			10c. CI1	Y, TOWN	OR LOCA		1tim					10d. INSIDE	
	Maryland 100. STREET AND NUMBER	N/A							юте				1 XYES 2		
Z I	3109 Milfo			10	1. ZIP COD	2120	0.7		ing. Cit	USA		117			
FUNERAL	11. MARITAL STATUS	ord Ave	12. WAS DECEDEN	T EVER IN II C A	PMED	T 42	WM C DE	CEMPENT /		NIC ORIGIN? (S	analthi Yan	or No		— American	Indian
	1 Never Married 2	Married	FORCES? 1	X YES 2	NO		If yes, sp	ecify Cubi	ın, Mexica	in, Puerto Ricar	n, etc.)	01 110—	Black Speci	, White, etc.	irratest,
à l	3 Widowed 4 Divo	proed	1978-				1 YES	2 X NO	Specii	λ:			Speci	Blac	ck
	15. OEC	CEDENT'S EOUC	CATION	16a. D	ECEDENT'S	USUAL O	CCUPATI	ON on work	na.	16b. KIN	O OF BUS	INESS/IN	DUSTRY		
ᄪ	Elementary/Secondary (0		College (1-4 or 5 +	//	fe. Do NOT u	se retired.)	Garing III	Val or works	rig						
M M	12			Po	rter					Но	spita	11			
COMPLETED	17. FATNER'S NAME (First, M							18. MOT	NER'S NA	ME (First, Midd					
BE (Fran	ncis De	aux Robi							7				11man	
2	19a. INFORMANT'S NAME (1						Route Number, (7	
-	Mary Eliza				3109				nue	Balti					
	20a. METHOD OF DISPOSIT 1 Burlal 2 A Cremetto	ION on 3 - Remo	oval from State		e and date				11/	DATE			City or To		
	4 ☐ Donation 6 ☐ Other 21. SIGNATURE OF FUNERA			Metr	o cre	mato	ry,	THC.	TT/	0/93			nore,		
1	21. SIGNATURE OF FUNERA	SERVICE LIC	Dawn :	F. McDo	na1d	C	rema	ition	Soc	eiety o	f Ma	ryla	nd,	Inc.	
	OW	70. N	LAON	all		2	99 I	rede	rick	Rd. E	Balti	more	, MD	21228	
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such ea cardisc or respiratory errest, ahock, or heart failure. List only one ceuse on each line. Approximate Interval Between Once and Reath														
	disease or condition 1/1 <											morths)			
	DUE TO (OR AS A CONSEQUENCE OF):														
Z	Sequentially the condition a HIV infection 10 year											years			
CERTIFICATION	Sequentially list conditions, If any, leading to immediate											,			
2	CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF):														
Ē	that initiated events resulting in deeth) LAST														
핑			d												
	PART II. Other algnifica		- 00		t resulting	In the u	ınderiyli	ng ceuse	given in	Part I. 24	e. WAS AN PERFOR		246	WERE AUTOP	
EDICAL.	Thromboup	to perma,	neutropeni	a.						1	YES 2	NO		OF DEATH?	OF CAUSE
ME														1 TYES 2	□ NO
ä	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO W UNCERTAIN														
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL 28. PLACE DF DEATH (Check only one) EXAMINER? OTHER:														
YSI	1 TES 2 NO		1 Inpetient 2			4 🗆 Nu	ursing Ho		Pesidence	8 Other (S					
표	27. MANNER OF DEATH 1 X Natural 5	Pending	28a. DATE OF (Month, L	Day, Year)	28b. TII	WE OF JURY	W	JURY AT	- NO	28d. DESCR	IBE HOW I	NJURY O	CCURED		
BY	2 Accident	Investigation	280 PLACE (OF INJURY — At	home term	etenat fo			□ NO	201 LOCATE	OBJ /Street (and Mumb	er or Burel	Route Number,	
G	3 Suicide B 4 Nomicide	Could not be determined	building	, etc. (Specify)	monne, tanin,	ationt, re-	ctory, orn	icw.		City or 1	fown, State)	srio realiza	er or riorer	noute trumber,	
듸	29a. CERTIFIER														
M	(Check only		CIAN: To the best of											A risa militari	
COMPLETED	2 MEL		R: On the beals of e	valentiation and/	or miveatigat	on, in my	оринюп,				u prace, an				
BE	296. SIGNATURE AND TITL	E OF CERTIFIE	R	110					CENSE NU				11/6/	(Month, Day,	Year)
2	Shows	OF PERSON WN	> ACUS	AC ISE OF DEATH (IT	TEM AT AT	. 04		1	353	65			11/6/	7)	
	5. Mars		BVANC				R.	16.		401	12-	à			
		(Year)	32, DEGISTR	AR'S SIGNATURE	Theme	_01,	Dh	4)m	re	MId. 5	-160	1			
	31. DATE FILES (MORE) Day	71995	Jali	AR'S SIGNATURE	Park III										
			0											OH	MH-16 Rev 1/89

BALTIMORE, MARYLAND 21215-0020

TO THE MOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hos	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detach		IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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	505					20)]] [
	1 - STATE REGISTRAR	STATE OF MARYLAND	/ DEPARTMENT (CERTIFICATE (F HEALTH AND OF DEATH	MENTAL HYGIEN REG. NO	E							
	1. DECEDENT'S NAME (First, Middle, Last) EDNA ELIZ	ABETH RE	EASIN		2. DATE OF DEATH MONTH D.	AV /9 95	3. TIME OF DEATH 2:05 A M						
	4. SOCIAL SECURITY NUMBER	5. SEX 8. AGE (In yrs. i	last birthday) IF UNDER 1 Y	AR IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHI Country	PLACE (State or Foreign						
	214-01-3236 Sa. FACILITY NAME (If not institution, give s	1 MXX F 85	YRS.	WN OR LOCATION OF D	AUG. 29,1	910 MA	RYLAND						
DIRECTOR	UNION MEMORIAL			ALTIMORE		N/A	ATH						
REC	10e. STATE 10b. COUNTY		10c. CITY, TOWN OR I				10d. INSIDE CITY LIMITS?						
	MARYLAND	N/A	В	ALTIMORE	CITY		XX YES 2 NO						
FUNERAL	100. STREET AND NUMBER 517 EAST 28	th. STREET		101. ZIP CODE 212	18	U.S.							
BY FUN	11. MARITAL STATUS XIX Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U.S. A FORCES? 1 YES TO SEE YES, GIVE WAR OR DATES	NO If ye	DECENDENT OF HISPA s, specify Cuban, Mexic YES X NO Specif	NIC ORIGIN? (Specify Yes an, Puerto Rican, etc.) fy:	or No— 14. RACE Black, Specifi	— American Indian, White, etc.						
	15. DECEDENT'S EDU	CATION 16a. I	DECEDENT'S USUAL OCCU	PATION	16h KIND OF BUIL	WH SINESS/INDUSTRY	ITE						
COMPLETED	(Specify only highest grade Elementary/Secondary (0-12) 12 YEARS	completed)	(Give kind of work done duril te. Do NOT use retired.) EXAMINER		СГОТН		MPANY						
	17. FATHER'S NAME (First, Middle, Last)	EASIN	N-W	18. MOTHER'S NA	AME (First, Middle, Malden	Sumame) AURICE							
BE	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING ADDRESS (S										
5	E.CHRISTINE RE	ASIN (SIS.)			ET, BALTIM		.,21218						
	20a METHOD OF DISPOSITION	oval from State cemetery c	E AND DATE OF DISPOSITION (Income to rematory or other place)			CATION — City or Tox							
	4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LIC	MORI	ELAND MEM	PARK CEN	1.11-3 BA	LTO.,MD	.,21234						
	· R. H. But	VI.	1	HENRY W.	JENKINS		SONS						
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardisc or respiratory arrest, shock, or heart fellure. List only one cause on each line. Approximate interval Batween												
	IMMEDIATE CAUSE (Final disease or condition												
	DUE TO (OR AS A CONSEQUENCE OF):												
NO	Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): WEEKS												
CAT	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury CAUSE (DIsease (Disease or Injury CAUSE (Di												
CERTIFICATION	that initisted events resulting in death) LAST	DUE TO (OR AS A CONS	EQUENCE OF):										
CER		d											
CAL	PART II. Other significent conditions contributing to desth but not reaulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? AN CO												
MEDICA	9 90				1 TES #	□ NO	OF DEATH?						
	DID TOBACCO USE CONTI	RIBUTE TO CAUSE OF DE	ATH YES NO	UNCERTAL	N 🗆	114							
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	ACE OF DEATH (Check only OTHER:	one)									
HYS	1 YES 2 NO 27. MANNER OF DEATH	Inpetient 2 ER/Outpatient		Home 5 Residence	8 Other (Specify) 28d. DESCRIBE HOW II	HIST OCCUBED							
ВУ Р	1 Netural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJURY	WORK? YES 2 NO		WONT COCCIED							
ETED E	3 Suicide 6 Could not be datermined	28a. PLACE OF INJURY — At h building, atc. (Specify)	nome, farm, street, factory,	office	26f. LOCATION (Street a City or Town, State)	nd Number or Rural Ro	oute Number,						
COMPLE		CIAN: To the bast of my knowledge, on the basis of examination and/or					and menner ex stated.						
	2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, end due to the ceuse(s) and the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, end due to the ceuse(s) and the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, end due to the ceuse(s) and the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, end due to the ceuse(s) and the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, end due to the ceuse(s) and the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, end due to the ceuse(s) and the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, end due to the ceuse(s) and the basis of examination and of the basis of examination and/or investigation.												
8	296. SIGNATATINE AND TISES OF CERTIFIES			D33 8	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Robert Vissing, MD 4300 N. Charles St Baltimer MD 21218								
	30. NAME AND ADDRESS OF PERSON WHI	D COMPLETED CAUSE OF DEATH (IT	EM 27) (Type, Print) 4300 A.			> 11/11/	145						

, , , , , ,

3. TIME OF DEATH 435

10d. INSIDE CITY

1 - YES 2 NO

BIRTHPLACE (State or Foreign

Maryland

Prince George

10g, CITIZEN OF WHAT COUNTRY?

Specify:

white

United States

14. RACE — American Indian, Black, Whits, atc.

21227

Arbutus

21227

24b. WERE AUTOPSY FINDINGS

AMAILABLE PRIOR TO

1 YES 2 NO

COMPLETION OF CAUSE

Approximate interval Batween

Onset and Death

9c. COUNTY OF DEATN

REG NO 2 DATE OF DEATN

976

Ovember

ITEMS:

FOR STATE REGISTRAR

t. DECEDENT'S NAME (First, Middle, Last)

4. SOCIAL SECURITY NUMBER S. SEX 7. DATE OF BIRTH (Month, Day, Year IF UNDER 1 YEAR IF UNDER 24 HRS. L M 2 F 217-17-8118 Q June 1 Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR Prince Georges Medical Center Chever1v 10b. COUNTY 10c. CITY, TOWN OR LOCATION Maryland Baltimore Halethorpe permit. FUNERAL tof ZIP CODE the burial-transit 1717 Arbutus Avenue 21227 retained by the hospital or attending physician. t3. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No—it yes, specify Cuban, Mexican, Puerto Rican, atc.)
t YES 2 NO Specify: 12. WAS DECEDENT EVER IN U.S. ARMED tt. MARITAL STATUS FORCES? 1 YES 2
IF YES, GIVE WAR OR DATES t Never Married 2 Married BY 3 Widowed 4 Divorced 35 ETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY use (Specify only high (Give kind of work done life. Do NOT use retired.) jo Elementary/Secondary (0-t2) College (t-4 or 5 +) COMPL page 5 should be detached N/A Student once. 17. FATNER'S NAME (First, Middle Last) ts. MOTHER'S NAME (First, Middle, Maiden Surname) Ħ Paul E. Riggs Christina S Pinheiro BE notified 19a, INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Christina Riggs Arbutus Avenue Halethorpe, Maryland after death. Page 6 may be 90 20a. METHOD OF DISPOSITION 20c. LOCATION — City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20s. METHOD OF DISPOSITION
t Burlel 25 Cremetlon 3 Removal from State
4 Donation 5 Other (Specify) must funeral director, Crematory Metro Catonsville, Maryland examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSE 22. NAME AND ADDRESS OF FACILITY Ambrose Funeral Home, Inc. 1328 Sulphur Spring Road the medical 23. PART. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. filled in by IMMEDIATE CAUSE (Finel the altiple inpenes disease or condition completely event, resulting in death) O (OR AS A DOMENCE OF) burial. other traumatic CERTIFICATION and Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): 9 If any, leading to immediate cause. Enter UNDERLYING physician Hygiene prior CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF) the attending p thet initieted events reaulting in death) LAST 6 Injury, PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY MEDICAL and a PERFORMED? any Health a 1 TYES 2 NO Shows has been s Dept. of H DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES INO I UNCERTAIN I PHYSICIAN: OR ATTENDING PHYSICIAN: The law 26. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL Item certificate to the State EXAMINER? or this cer.
** with the Sta. HOSPITAL: t 🗆 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 10-28-9 28c. INJURY AT WORK?
t YES 2 NO 28b. TIME OF 28d. DESCRIBE HOW INJURY OCCURED marked, 640A 1 Natural 5 Pending BY 2 Accident After t 28t. LOCATION (Street and City or Town, State) 28s. PLACE OF INJURY -building, etc. (Specif Sulcide 69 DIRECTOR: A COMPLETED 4 Homicide 28 datarmined AT EXIT 4 OXON HILL, MARYLAND Item 29a. CERTIFIER

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. TO THE FUNERAL DE FILE WITHIN 72 h (Check only one) HOSPITAL 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, 29b. SIGNATURE AND TITLE OF CERTA BE 포포 223 9 WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Kaypum

2. REGISTRAR'S SIGNATURE

.28e,28f, PER MEO FILM G-729 11/30/95 t.t

149

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

DHMH-18 Rev 1/89

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TIMOTHY
31. DATE FILEO (MONTH, Day,
NOV 0

7 1995

32 REGISTRAR'S SIGNATURE

	FOR	STATE OF MARYL	AND / DEDARTI	MENT OF U	EALTH AND	MENTAL HVO	70	33300		
	1 - STATE REGISTRAR	SINIE OF MANTE	CERTIFIC	ATE OF	DEATH	MENIAL HYGI REG.				
	1. DECEDENT'S NAME (First, Middle, Last)	Patricia 5. SEX BAGE	Ross			2. DATE OF DEATH	DAY	YEAR 900 AM		
477100	212-207630 90. FACILITY NAME (If not institution, give s	10 M DF 72	YRS.	ONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH		B. BIRTNPLACE (State or Foreign Country) May Jane		
TOR	RESIDENCE OF DECEDENT	treet and number)		a 1.1	A LOCATION OF D	EATH	9c. COUN	NTY OF DÉATN // N/A		
DIRECTOR	Maryland Balt	imore		own on Locati	ON			10d, INSIDE CITY LIMITS? 1 YES 2 NO		
FUNERAL	100. STREET AND NUMBER 5912 Franklin Avenue			101.	ZIP CODE 21207			ZEN OF WHAT COUNTRY?		
BY	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2 1 NO	If yes, spe	NOENT OF NISPAI city Cuben, Mexica 2 ANO Specif	NIC ORIGIN? (Specify an, Puerto Rican, etc. y:	Yes or No-	14. RACE — American Indian, Black, White, etc. Specify: White		
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)		18e. DECEOENT'S US (Give kind of work life. Do NOT use n Claims Au	k done during mos atired.)	N t of working	VV 325-2	Security	2,		
BE CON	17. FATHER'S NAME (First, Middle, Lest) Charles Barbour				18. MOTHER'S NA Marion	ME (First, Middle, Mai Scott	den Surname)			
TOB	190. INFORMANT'S NAME (Type/Print) Edith Barbour (sis	ter)				Aoute Number, City or timore, Mar				
	20s. METNOD OF DISPOSITION 1 X Buriel 2 Cremation 3 Rem 4 Donation 5 Other (Specify)	oval from State 20b.	PLACE AND DATE OF Contents W Cathedral	pisposition (Name of piace) Cemetery	Nov. 8,	0ATE 20c.		City or Town, State , Maryland		
	21. SIGNATURE OF FUNERAL SERVICE LIC	Withe &	2	Leroy M 1630 Edr	ADDRESS OF FA L. & RUSSE Mondson Av	oury 11 C. Witzk venue Cator	e Funera	al Homes Maryland 21228		
	IMMEDIATE CALICE (Float	a. Amyotru	ch line.	enter the mod	e of dying, suc	h aa cardiec or re	apiratory arre	Approximata Interval Between Onset and Death 2 Years		
CERTIFICATION	Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. OUE TO (OR AS A CONSEQUENCE OF): OUE TO (OR AS A CONSEQUENCE OF):									
4	PART II. Other significent conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY PRIDING AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO									
PHYSICIAN: MEDICA	DID TOBACCO USE CONTI		DEATH YES	-	UNCERTAIN	v 🗆		1 🗆 YES 2		
YSIC	EXAMINER?	HOSPITAL:	O	THER:	5 🗆 Residence	6 Other (Specify)				
ВУ РН	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME O	M 1 YE	28d. DESCRIBE NOW INJURY OCCURED WORK? YES 2 NO					
a	3 Suicide 8 Could not be determined	28e. PLACE OF INJURY - building, atc. (Specif	y)			City or Town, St.	rfe)	or Rurel Route Number,		
COMPLET		CIAN: To the best of my knowle R: On the beste of examination						od. o cause(s) and manner se stated.		
BE	296. SIGNATURE AND TITLE OF CERTIFIEF Timothy. J.	· Veny	2nD		29c. LICENSE NUN	IBER	29d. DATE	SIGNED (Month, Day, Year)		
임	30. NAME AND ADDRESS OF PERSON WAY	COMPLETED CAUSE OF DEAL	TAL OTTEM OT OTHER	-41						

REAWARD ST

BATTIMORE MA

BALTIMORE, MARYLAND 21215-0020

should

DIRECTOR

FUNERAL

ВУ

ETED

COMPL

2

CERTIFICATION

MEDICAL

PHYSICIAN:

ВУ

COMPLETED

BE

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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	THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlal-transit permit. Pages filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlal, cremation, or removal.	
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5	O THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician effed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to	MPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at on
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 1995 3:30 CHESTER ROGINSKI 2 Nov. 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTH 1912 8. BIRTHPLACE (State or Foreign HOURS 137-03-7428 1 X M 2 - F 83 YRS. 15 March Poland 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Johns Hopkins Bayview M.C. Baltimore Baltimore City RESIDENCE OF DECEDENT 10c CITY TOWN OR LOCATION 10a, STATE 10b. COUNT 10d. INSIDE CITY Maryland Dunda1k Baltimore 1 TYES 2 X NO 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 1937 Snyder Ave USA 21222 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married II yes, specify Cuban, Mexican, Puarlo Rican, etc.)

1 YES 2 NO Specify: 3 Widowed 4 Divorced White 16a. DECEDENT'S USUAL OCCUPATION
(Oive kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only hig Elementary/Secondary (0-12) College (1-4 or 5+) 6 Brewery worker Brewing 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Melden Surname) John Roginski Unknown 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Adele Roginski 1937 Snyder Ave. Baltimore, Md. 21222 20a. METHOD OF DISPOSITION
1X Burlal 2 Cremetton 3 Removal from State
4 Donetton 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State Gardens of Faith Cem 11-6 Baltimore, Md. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Connelly Funeral Home of Dundalk 23. PART I. Enter the displaces, or complications that caused the death. Do not enter the mode of dying, such as cardiec or reapiratory erreat, shock, or heart fellure. List only one cause on each light.

AUTH 7110 Sollers Point Rd. 21222 Approximete Interval Between Onaet and Death MYOCARDIAL INFARCTION, ACUTE disease or condition___ 1 HOUR resulting in death) THEROSCLEROTIC CARDIOVASCULAR DISEASE 4 YEARS Sequentially list conditione, DUE TO (OR AS A CONSEQUENCE OF) It any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF) that initiated evente resulting in death) LAST PART II. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Pert I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS HYPERTENSION AWAILABLE PRIOR TO SYSTOLIC COMPLETION OF CAUSE 1 | YES 2 | NO FIBRILLATION, CHRONIC 1 YES 21 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO IN UNCERTAIN I 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) EXAMINER? HOSPITAL: | | Inpatient 2 | ER/Outpatient 3 | DOA 4 Nursing Home 5 Realdence 6 Other (Specify) 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 26d, DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending investigation 1 YES 2 NO 2 Accident 28e. PLACE OF INJURY — At home, larm, street, lactory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) e Could not be 4 Homicide 29s. CERTIFIER
(Chack nniv 1 CERTIFYINO PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and menner as stated. 206 SIGNATURE AND TITLE OF CERTIFIER 29 LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 11502 * gwaren 3/95 30. NAME AND AUDRESS OF PERSON WHO COMPLETED QUISE OF DEATH (ITEM 27) (Type, Print)

Teodulo J. Paglinauan Jr. M.D. 7811 Wise Ave Baltimore, Md 21222 22 State of State of

	1 - STATE REGISTRAR	STATE OF MAI		ARTMENT OF		MENTAL	HYGIENI REG. NO.	E				
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE O	OF OEATH		T	3. TIME OF DEATH		
	SANFORD A	BBE SCHNEIDER					. 2,	1995	FAR	11:45 A.M		
	4. SOCIAL SECURITY NUMBER	5. SEX 6.	AGE (In yrs. lest birthde	WONTHS DAYS	IF UNDER 24 HRS.	7. DATE C	OF BIRTH	8.	BIRTHI	PLACE (State or Foreign		
	214-60-1018 9a. FACILITY NAME (If not institution, give str	1 M 2 F	M 2 □ F 43 YRS. 2-29-1952 TE							NESSEE		
TOR	SUBURBAN HOSPIT			MONTG		EATH .				OMERY		
DIRECTOR	108. STATE 106. COUNTY MARYLAND N/		10c.	BALTIM				10d, INSIDE CITY LIMITS? 1 YES 2 NO				
FUNERAL	320 SOUTH ANN S	STREET		10	21231			U.S.		HAT COUNTRY?		
B≺	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EX FORCES? 1 I	YES 2 NO	If yes, s	CENDENT OF HISPAI pecify Cuben, Mexica S 2 NO Specifi	n, Puarlo R		or No 14	I. RACE Black, Specif	- American Indian, White, etc.		
TEO	15. DECEDENT'S EDUC (Specify only highest grade of		(Give kind	T'S USUAL OCCUPAT of work done during m	ON ost of working	16b.	KIND OF BUS	INESS/INDUS	TRY			
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)		Tuse retired.) NET MAK	ER	C	CABINI	ET MA	KE	R		
SO S	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA							
BE (NATHAN SCHNEII	DER			ROSAL							
2	19a. INFORMANT'S NAME (Type/Print)			ING ADDRESS (Street						205		
	ALAN J. SCHNEI	LDER		N. 22N			_					
	20s. METHOO OF DISPOSITION 1 Burlal 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) CREMATORY 1/95 BALTO., MD.											
	21. SIGNATURE OF FUNERAL SERVICE LICE VILLIAM R	. Caris II		HEN	ND ADDRESS OF FA RY W. J 5 YORK	ENKI						
	23. PART I. Enter the diseases, or c shock, or heart failure. I. IMMEDIATE CAUSE (Final disease or condition resulting in death)	lat only one cause	on each line.					ratory arres	st,	Approximate Interval Between Onset and Death		
CERTIFICATION	Sequentially list conditiona, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST		AS A CONSEQUENCE									
PHYSICIAN: MEDICAL C	DARK II ON THE STATE OF THE STA								WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 XYES 2 NO			
ž	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN											
SICIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 X YES 2 NO	HOSPITAL:		OTHER:	ne 5 🗆 Residence	6 X Other	(Snacity)	UTSI	DE	OF E.R.		
Ή	27. MANNER OF DEATH	28e. DATE OF INJ	URY 28b.	TIME OF 28c. IN	JURY AT		CRIBE HOW I					
BYF	1 Natural 5 Pending	11/2/9	114		YES 2 NO	SUE	STECT	SHOT	- St	31		
	3 Suicide 6 Could not be	2 Accident investigation 3 Suicide 6 Could not be building atc. (Specify)						281. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
	4 Homicide determined		IN PRONT	of Hospit	AL	BUBU	LEBAL) HUSPI	TAIL	, MONITGOINE		
COMPLETED	29a. CERTIFIER (Check only prei) 1 CERTIFYING PHYSIC (Check only prei)	CIAN: To the best of my								and manner as stated.		
	FRIL SHANGELINE, AND TITLE OF CENTIMEN	00	h	- Johnson	29c. LICENSE NUI		,			(Month, Day, Year)		
TO BE	Houng	Soll	Atw	l.	O.C.M			▶ NO		3, 1995		
-	MARIO & GOLIES	R MO	_/ 111		reet, B	alti	more	, Mar	yla	and 21201		
	" NOV 0 7 1995 /	L. SHERREN S	PUNCHES .									

AL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	L DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	Pours after death with the State Dept. of Health and Mental Hygiene prior to bunal, cremation, or removal.	STANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	
TO THE HOSPITAL OR ATTENDING PI	TO THE FUNERAL DIRECTOR: After this	be filed within 72 hours after death with the	IMPORTANT: If item 28 Is mark	

	1 - STATE OF				F HEALTH AND I	MENT	AL HYGIENI	E			
	1. DECEDENT'S NAME (First, Middle, Last)			OATE (JI DEATH		TE OF DEATH			3. TIME OF DEATH	
	Geraldine Sapp					NO	v. 4		95	M	
	4. SOCIAL SECURITY NUMBER 5. SEX	6. AGE (In yrs la	st birthday)	IF UNDER 1 YE		7. DAT	TE OF BIRTH onth, Day, Year)		s. BIRTH	PLACE (State or Foreign	
	213-30-5876 1□M25x	87	YRS.	MONTHS DA	YS HOURS MIN.		b. 5,1	908	Mar		
	9a. FACILITY NAME (If not institution, give street and number)								NTY OF DE		
DIRECTOR	St. Flizabeth's 3320			Ba1t	imore			N/A			
E I	10a. STATE 10b. COUNTY			Y, TOWN OR L						10d, INSIDE CITY LIMITS?	
PIG	Maryland N/A		Ba	Baltimore				1 XYES 2 NO			
AL	10e. STREET AND NUMBER			10f. ZIP CODE				10g. CITIZEN OF WHAT COUNTRY?			
IER	2677 Wilkens Avenue		21229			Uni	ted	States			
FUNERAL	FORCES	DENT EVER IN U.S. A			DECENDENT OF HISPAI			or No-	or No — 14. RACE — American Indian, Black, White, etc.		
ВУ		E WAR OR DATES	If yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 YES 2 NO Specify:				, , , , , , , , ,	Specify:			
	15. DECEDENT'S EDUCATION	16a D	ECEDENTIS	USUAL OCCU	PATION	1	I6b. KIND OF BUS	INECC/IN	Whi	te	
COMPLETED	(Specify only highest grade completed)	(i		vork done durir	g most of working		IOU. KIND OF BOO	MINESSAIN	J031H1		
PE	Elementary/Secondary (0-12) College (1-4 o		cler	k			baker	CV			
MO	17. FATHER'S NAME (First, Middle, Lest)		CICI.	12	18. MOTHER'S NA	AME (Firs					
	Francis Stock				Mary	Mi1	ler .				
BE	19a, INFORMANT'S NAME (Type/Print)	-1	9b. MAILING	ADDRESS (SI	reet and Number or Rural			n, State, Zi	p Code)	21229	
٥	John Sapp		2677	Wi1k	ens Aven	ue	Baltin	nore	, Mai	ryland	
	20a. METHOD OF DISPOSITION 1 SpBuriel 2 Cremation 3 Removal from State	20b. PLACE	E AND DATE	OF DISPOSITIO					City or To		
	4 Donation 6 Other (Specify)		owr.i	dae_M	emorial	11/	'8 Doi	csey	, M:	aryland	
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE		12.1	22. NA	ME AND ADDRESS OF FA	ACILITY		_ T	· ~ ~	Arbutus	
	DOZT S		2		rose Fun 8 Sulphu					21227	
	23. DART I. Enter the diseases, or complications									Approximate	
	shock, or heart failure. List only one	with proper to								Interval Between Onset and Death	
	disease or condition	uton	MII A	m a i	diali	رك	a sect	213		6000	
	resulting In death) e. U.C.	TO (OR AS A CONS	EOUENGE O	F):	1	1	,0-01			10000	
z	- ari	erio	rel	eral	10 000	na	ryde	se	Bec	year	
0 L	disease or condition resulting in death) • Acute my or cardial unfarction hour, DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):										
2	CAUSE (Disease or Injury										
E	that initiated events resulting in death) LAST										
CERTIFICATION	d										
AL (PART II. Other aignificant conditions contribution	to death but not	reauiting	In the unde	rlying ceuse given in	n Part I.	24a. WAS AN PERFOR		24b	WERE AUTOPSY FINDINGS	
						1 TYES 2			COMPLETION OF CAUSE OF DEATH?		
MEDIC										1 _ YES 2 _ NO	
ä	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN										
CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		ACE OF DEA	TH (Check only	one)					T LU	
rsi	HOSFITAL	2 ER/Outpatient	3 🗆 DOA	4 1 Nursing	Home 5 Residence	8 🗆 0	ther (Specify)				
PHYSICIAN:	(Mor	E OF INJURY th, Day, Year)	28b. TIN	JURY	c. INJURY AT WORK?	28d. l	DEŞCRIBE HOW I	NJURY O	CURED		
В	1 Natural 5 Pending 2 Accident Investigation				YES 2 ND	<u> </u>					
ED		CE OF INJURY — At I ling, atc. (Specify)	home, farm,	atreet, fectory	office		OCATION (Street in City or Town, Stete)	(Street and Number or Rural Route Number, n, Stete)			
Ш											
COMPL	29a. CERTIFIER (Check only										
ON	2 MEDICAL EXAMINER: On the beels	of axamination and/o	or investigation	on, in my opin	ion, death occured at the	ne time, d	late and place, en	d dua to t	the cause(s	i) and manner as stated.	
ш	BINGNATURE AND TITLE OF CENTIFIED				29c. LICENSE NU	UMBER	2/	29d. DA	TE SIGNED	(Month, Day, Year)	
TO B	Jaurence (Vall	pen 1	MO		1001	18	6	1	10V.	7,1995	
-	30. NAME AND ADDRESS OF PERSON WIND COMPLETED L. GALLAGER, M.D. 3	CAUSE OF DEATH (IT	TEM 27) (Type	NS AU	E, BAL	70	, NO ?	2/2	22	9	
	31 DATE EILED (Month Day Year) 32 REGI	TRAR'S SIGNATURE			,					•	
	NOV 0 71995 Jahi da	whereast	4								

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or stending physician.

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IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CEF	RTIFIC	ATE OF	DEATH	RI	EG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF D	EATH	,	VEAD	3. TIME OF DEATH
	ALIZA				SHE	IN	NOVEM	BER	2, 19	995	9:25am w
,	4. SOCIAL SECURITY NUMBER		E (In yrs. lest bi	MO	UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF B (Month, Day	IRTH (, Year)		Country	PLACE (State or Foreign
	042-36-6910	1 🗆 M 2 🔀 F	85	YRS.		271011 2200	JULY	1, 19		ISE	RAEL
œ	9a. FACILITY NAME (If not institution, give s		Dm 2	96		OR LOCATION OF DE	ATH			NTY OF DI	EATH
DIRECTOR	5025 GREENMOUNTAI	N CIRCLE, A	PT. 3		COL	JMBIA			HOW	ARD	
3EC	10e. STATE 10b. COUNTY	1		10c. CITY, T	OWN OR LOC	TION					10d. INSIDE CITY LIMITS?
ă	MARYLAND H	OWARD			COLU	MBIA					1 XYES 2 NO
AL	10e. STREET AND NUMBER				- 1	H. ZIP CODE			10g. CIT	ZEN OF W	HAT COUNTRY?
FUNERAL	5025 GREENMOUNTAI	N CIRCLE, A	PT. 3			21044				USA	
5	11. MARITAL STATUS t Never Married 2 Married	t2. WAS DECEDENT EVER FORCES? 1 1 YE		D	13. WAS DE	CENDENT OF HISPAN pecify Cuben, Maxica	IIC ORIGIN? (Sp n, Puerto Ricen	pecify Yes	or No-	14. RACE Black	— American Indian, , White, efc.
ВУ	3 X Widowed 4 Divorced	IF YES, GIVE WAR OF				S 2 X NO Specify				Specif	WHITE
	15. DECEDENT'S EDU	CATION	16a, DECE	DENT'S US	UAL OCCUPAT	ION	t6b, KIN	D OF BUS	INESS/INC	OUSTRY	WILLE
ETE	(Specify only highest grade Elementary/Secondary (0-12)	Completed) College (1-4 or 5+)	(Give	kind of work o NOT use re	done during national.)	ost of working					
뒫	12				HOUS	EWIFE			OWN	HOME	3
COMPLETED	17, FATHER'S NAME (First, Middle, Last)					16. MOTHER'S NA	ME (First, Middle	s, Maiden I	Surname)		
BE (JOSEPH	KANDINO	FF			CH	ANA			BURT	ON
5	19a. INFORMANT'S NAME (Type/Print)					and Number or Rural I					
	MRS. JUDY	SATIN			-	VCE CIRCL					
	20a, METHOD OF DISPOSITION 1 Remarks 2 Cremetion 3 Rem	oval from State	20b. PLACE AN	DDATE OF D story or other	place)	lame of	DATE	20c. LOC	CATION —	City or To	WIN, State ALLSTOWN, MD
	4 Donation 6 Other (Specify)		LIBEKT.	Y PAR		ND ADDRESS OF FA		-3-I	995-I	RANDA	ALLSTOWN, MD
	▶ allengu	4.1	MA-			LEVINSON		., I	NC.		
	1000			7		REISTERS					E, MD 21215
	23. PART i. Enter the diseases, or a ahock, or heart failure.	complications that cause or List only one cause or	sed the deet n each line.	h. Do not	enter tha m	ode of dying, auc	h aa cardlac	or reapli	ratory an	rest,	Approximata Interval Between
	IMMEDIATE CAUSE (Finel disease or condition	0		1							Onset and Death
	reaulting in death)	a. Cardio	S A CONSEQU	ENCE OF	24 1	14007					
_					mania						2 4 \
ō.	Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING b. Aspiration Previous Due to (or as a consequence of): Consestive Heart Enteru										
CERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury CAUSE (Disease or injury										
E	thet initiated events	DUE TO (OR A	S A CONSEOU	ENCE OF):							
Ä	resulting in death) LAST										
	PART II. Other algnificent condition	ns contributing to deet	but not res	suiting in 1	the underlyl	ng ceuse given in	Part I. 24a	. WAS AN		24b	WERE AUTOPSY FINDINGS
DICAL	Polycy themin yera, Atrial Fibrillation, PERFORMED?							AMILABLE PRIOR TO COMPLETION OF CAUSE			
MED							_ '	,	1		t YES 2 NO
ä	DID TOBACCO USE CONT	RIBUTE TO CAUSE	OF DEATI	H YES	□ NO	W UNCERTAIL	N 🗆				1
SIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE		Check only on	9)					
SIG	t YES 2 NO	t Inpatient 2 ER/C	Outpetlant 3		THER:	me 5 Residence	6 Other (Sp	recify)			
PHYSICIAN:	27. MANNER OF DEATH	26a. DATE OF INJUI (Month, Day, Yea		26b. TIME C	Y V	JURY AT ORK?	26d. DESCRIE	BE HOW IN	NJURY OC	CURED	
ВУ	1 Netural 5 Pending 2 Accident Investigation					YES 2 NO					
03	3 Suicide 6 Could not be 4 Homicide determined	28a. PLACE OF INJU building, etc. (5	JRY — At home Specify)	e, farm, stre	el, factory, of	lca	261. LOCATIO City or To	N (Street a own, State)	nd Numbe	r or Rural F	Route Number,
ET	20a CENTIFIED and			_							
COMPLET	(Check only	ICIAN: To the best of my kr									
8		ER: On the basis of exemina	ition and/or inv	restigation,	In my opinion			place, and			
B	296. SIGNATURE AND TITLE OF CERTIFIE	m)-				D30				TE SIGNED	(Month, Day, Year)
2	30. NAME AND ODRESS OF PERSON WI	O COMPLETED CAUSE OF	DEATH (ITEM	27) (Type. Pr	int)	1330	3 1 3		- 1		13
		All buture				ridmul	MO	٦.	104	4.	
	31. DATE FILED (Month, Day, Year)	32. REMSTRAB'S S	IGNATURE						1 - 1		
	NOV 0 7 199	Jaki dhu	dearke	wall							

F 77 77

nours after death, Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020

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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within minus after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buriar-transit permit. Pages 1, 2, 3 should
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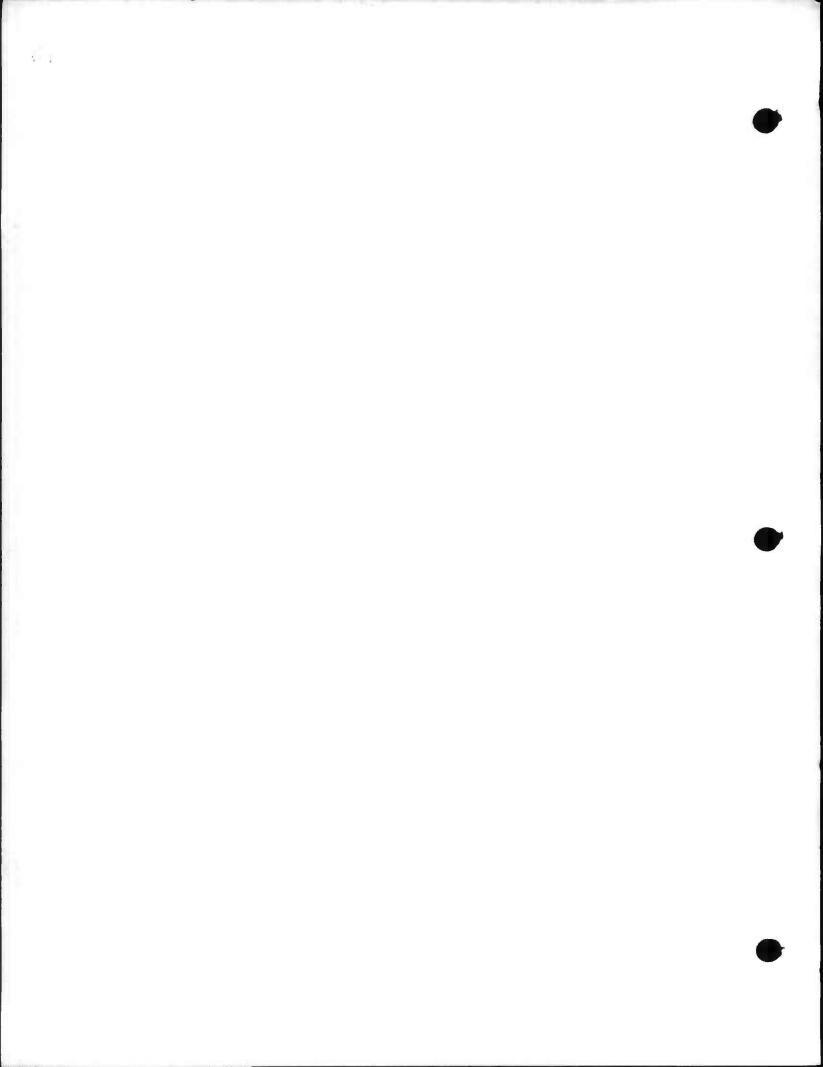
161-20-2820										
161-20-2820 I w 2 Si F 68 YYS. SOUTH DATE OF STORY SOUTH D	3. TIME OF OEATH									
30 Filmore Drive 30 Filmore D	11: 50 p. M THPLACE (State or Foreign									
THE THE THE PARTY OF THE THE THE DESIRE OF PRICE DEATHY THIS TOTAL THE	sylvania									
St. STREET AND NUMBER 10. STREET AND NUMBER 10. WAS DECEDENT EVER IN U.S. ARMED 10. WAS DECEDENT EVER IN U.S. ARMED 11. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Vas or No. 1 In RACE 11. Nove Married 2 Married 2 Married 2 Married 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Vas or No. 1 In RACE 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Vas or No. 1 In RACE 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Vas or No. 1 In RACE 13. WAS DECEDENT OR HISPANIC ORIGIN? (Specify Vas or No. 1 In RACE 13. WAS DECEDENT OR HISPANIC ORIGIN? (Specify Vas or No. 1 In RACE 13. WAS DECEDENT OR HISPANIC ORIGIN? (Specify Vas or No. 1 In RACE 13. WAS DECEDENT OR HISPANIC ORIGIN? (Specify Vas or No. 1 In RACE 13. WAS DECEDENT OR HISPANIC ORIGIN? (Specify Vas or No. 1 In RACE 13. WAS DECEDENT OR HISPANIC ORIGIN? (Specify Vas or No. 1 In RACE 13. WAS DECEDENT OR HISPANIC ORIGIN? (Specify Vas or No. 1 In RACE 13. WAS DECEDENT OR HISPANIC ORIGIN? (Specify Vas or No. 1 In RACE 13. WAS DECEDENT OR HISPANIC ORIGINARY (Specify Vas or No. 1 In RACE 13. WAS DECEDENT OR HISPANIC ORIGINARY (Specify Vas or No. 1 In RACE 13. WAS DECEDENT OR HISPANIC ORIGINARY (Specify Vas or No. 1 In RACE 13. WAS DECEDENT OR HISPANIC ORIGINARY (Specify Vas or No. 1 In RACE 13. WAS DECEDENT OR HISPANIC ORIGINARY (Specify Vas or No. 1 In RACE 13. WAS DECEDENT OR NO. 1										
So. STREET AND MANIBER 30 Fillmore Drive 11. WAS DECEMBENT EPONGS 11. Nove Married 2 Merried 21. WAS DECEMBENT EPONGS 11. Nove Married 2 Merried 22. WAS DECEMBENT EPONGS 13. Nove Married 2 Merried 23. Wildwood 4 Dhoreofte Person (Nove Man on Darke) 14. Nove Married 2 Merried 25. Wildwood 4 Dhoreofte Person (Nove Man on Darke) 15. DECEMBENT EPONGS 16. DECEMBENT EPONGS 16. DECEMBENT EPONGS 16. DECEMBENT EPONGS 17. FATHER'S NAME (First, Model), Last) 17. FATHER'S NAME (First, Model), Last) 18. NAME (First, Model), Last) 19. MALLING ADDRESS (Simil and Number or Almal Routed Manibus or Routed Manibus or Almal Routed Manibus or Routed Manibus or	10d. INSIDE CITY									
Securities Sec	1 TYES 2 NO									
Securities Sec	CITIZEN OF WHAT COUNTRY?									
The state of the continued	CE — American Indian,									
South Comment	ock, White, atc. **Coffy: White									
South Comment										
South Companies South Comp	10									
South Comment	6									
198. MR. MAD ADNIES Sattsky 1421 CANTERBURY RD. RALEIGH, NC 27608										
A	8									
21. SIONATURE OF FUNERAL SERVICE LICENSEE 22. MANS AND ARRIVES ON BROS. INC. 6010 REISTERSTOWN RD. BALTO., M. 6010 REISTERSTOWN RD. BALTO., M. 8 BROS. INC. 6010 REISTERSTOWN RD. BALTO., M. 8 BALTO., M. 8 BALTO., M. 8 BROS. INC. 6010 REISTERSTOWN RD. BALTO., M. 8 BALTO., M. 8 BROS. INC. 6010 REISTERSTOWN RD. BALTO., M. 8 BALTO., M. 8 BROS. INC. 6010 REISTERSTOWN RD. BALTO., M. 8 BALTO., M. 8 BROS. INC. 6010 REISTERSTOWN RD. BALTO., M. 8 BALTO., M. 8 BROS. INC. 6010 REISTERSTOWN RD. BALTO., M. 8 BALTO., M. 8 BROS. INC. 6010 REISTERSTOWN RD. BALTO., M. 8 B	Town, Stata									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardisc or respiratory errest, shock, or heart feiture. List only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentielity list conditions, if any, leeding to immediate cause. Enter UNDERIVING CAUSE (Disease or Injury thet initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): with metastasis to liver and spine DUE TO (OR AS A CONSEQUENCE OF): with metastasis to liver and spine DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CON	4 Denetion 5 Other (Specify) BNAT TSRAEL 10/30/95 BALTIMORE, MD									
AND TO THE CAUSE (Finel disease or condition resulting in death) Sequentielly liet conditions, if any, leading to immediate course. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSE	MD 21215									
disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): with metastasis to liver and spine DUE TO (OR AS A CONSEQUENCE OF): with metastasis to liver and spine DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE	Approximate Interval Between									
DUE TO (OR AS A CONSEQUENCE OF): with metastasis to liver and spine DUE TO (OR AS A CONSEQUENCE OF): with metastasis to liver and spine DUE TO (OR AS A CONSEQUENCE OF): with metastasis to liver and spine DUE TO (OR AS A CONSEQUENCE OF):	Onset and Desth									
With metastasis to liver and spine Due to (or as a consequence of): Due to (or as a consequence of):	4–18–1995									
PART II. Other significent conditions contributing to deeth but not recuiting in the underlying ceuse given in Pert I. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO 26. PLACE OF DEATH (Check only one) 27. WANNER OF DEATH Normaling Nome 5 Residence 6 Other (Specify) 28. DATE OF INJURY AT WORK? 28. DATE OF INJURY AT WORK? 28. PLACE OF INJURY AT NORK? 28. DATE OF INJURY AT WORK? 28. PLACE OF INJURY AT NORK? 28. DATE OF INJURY AT NORK? 28. PLACE OF INJURY AT NORK? 28. DATE OF INJURY AT NORK? 28. PLACE OF INJURY AT NORK? 28. DATE OF INJURY AT NORK? 28. PLACE OF INJURY AT NORK? 28. DATE OF INJURY AT NORK? 28. PLACE OF INJURY AT NORK? 28. DATE OF INJURY AT NORK? 29. CERTIFIER (Check only one) 29. DATE SIGNED 29. CICENSE NUMBER 29. DATE SIGNED	with metastasis to liver and spine 5-8-1995									
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The street Section Secti	OF DEATH?									
The street Section Secti										
The street Section S										
The street Section S										
3 Sulcide 4 Homicide 5 Could not be datermined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner ea attend. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED										
296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED	Route Number,									
296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED										
296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED	(s) end menner se stated.									
	ED (Month, Day, Year)									
D33470 D30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF PEACH (ITEM 27) (Type, Print)	28, 1995									
Bhasker A. Jhaveri, M.D., Shanti Medical Center, Leonardtown, Maryland	20650									
31. DATE FILED (Month, Day, Year) NOV 0 71995										

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CONTROL ACTIVITY NO COTTY IGNICO THE CT	TO BE COMPLETED BY DHYSICIAN: MEDICAL CERTIFICATION
examiner must be notified at once.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	TO THE FUNERAL DIRECTOR: After this cardificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
death. Page 6 may be retained by the hospital or attending physician.	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a five death. Page 6 may be retained by the hospital or attending physician.
BALTIMORE, MARYLAND 21215-0020	DIVISION OF VITAL RECORDS, P.O. BOX 68760

	FOR STATE REGISTRAR	STATE OF MARYLA	AND / DEPART	TMENT OF H	IEALTH AND	MENTAL HYGIEN				
	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH		3. TIME OF DEATH		
	VINCENT R	OY SWEETS				MONTH C		12 · 10 A		
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (II	n yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	8.	BIRTHPLACE (State or Foreign		
	217-52-5722		46 YRS.	MONTHS DAYS	HOURS MIN.	MARCH 28,	1949 1	MARYLAND		
_	9a. FACILITY NAME (If not institution, give	street and number)			OR LOCATION OF D	EATH	9c. COUNTY			
E	STELLA MARIS-ME	RCY		BALT	IMORE		N,	/ A		
<u> </u>	RESIDENCE OF DECEDENT 10a. STATE 10b. COUN	TY	Inc. CITY	. TOWN OR LOCA	TION			10d, INSIDE CITY		
DIRECTOR	MARYLAND	N/A BALTIMORE						LIMITS?		
	10e. STREET AND NUMBER	101, ZIP CODE					N OF WHAT COUNTRY?			
FUNERAL	2231 W. SARATOGA	STREET			21223			SA.		
N	11. MARITAL STATUS	12. WAS DECEDENT EVER IN FORCES? 1 YES	U.S. ARMED	13. WAS DEC	a or No- 14.	14. RACE — American Indian,				
ВУ	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE WAR OR DA	TES		2X NO Speci	nn, Puerto Rican, etc.) ly:		Black, Whita, etc. Specify:		
	15. DECEDENT'S ED	I I I						BLACK		
H	(Specify only highest grad	de completed)	(Give kind of we life. Do NOT use	ork done during mo	ON ist of working	16b, KIND OF BU	ISINESS/INDUS	TRY		
PL	10th GRADE	College (1-4 or 5+)	LABOR	,		BALTIM	ORE CI	TY		
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				16. MOTHER'S NA	AME (First, Middle, Maider	Sumame)			
ш	NATHANIEL	SWEETS			HATTIE		THOMA	S		
TO B	19e. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street a	nd Number or Rural	Route Number, City or Toy	vn, State, Zip Co	de)		
-	HATTIE DA		740 P	OPLAR G	ROVE, BA	LTIMORE, M	IARYLAN	D 21216		
	20a METHOD OF DISPOSITION 1 ABurlat 2 Cremation 3 Res	movel from State 20b.	PLACE AND DATE O			DATE 20c. LC	OCATION — City	y or Town, State		
	4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE L		NG MEMOR			RY 11-7-95				
	21. SIGNAL ONE OF PURELAL SERVICE L	ICENSEE A		JOSEP	H H. BRO	WN JR. FUN	ERAL H	OME, P.A.		
	Ida	-1) 100 Y	~					ORE, MD.21223		
	23. PART i. Enter the diseeses, or ahock, or heart fallure	complications that caused. List only one ceuse on ea	the deeth. Do no	ot enter the mo	de of dying, suc	h es cerdisc or reep	Iratory srrest	t, Approximate Interval Between		
	IMMEDIATE CAUSE (Final disesse or condition	,						Onset and Death		
	resulting in death)	8	AIDS					unknow		
		DUE TO (OR AS A	CONSEQUENCE OF):						
CERTIFICATION	Sequentially list conditions, If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):									
§	rr sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease pr Injury									
E	that initiated events	DUE TO (OR AS A	CONSEQUENCE OF):						
	resulting in deeth) LAST	d								
AL C	PART II. Other eignificent condition	ns contributing to deeth bu	it not resulting in	the underlying	ceuse given in	Part i. 24e, WAS AN	AUTOPSY	24b. WERE AUTOPSY FINDINGS		
	PERFORMED? AMAILABLE PRIOR TO COMPLETION OF CA									
MEDIC	of the second of									
	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO WUNCERTAIN									
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	2	6. PLACE OF DEATH	H (Check only one)						
YSI	1 YES 24 NO	HOSPITAL: 1 Inpetient 2 ER/Outpe	itient 3 🗆 DOA	OTHER: 4 - Nursing Hom	e 5 🗆 Residenca	SM Other (Specify) H	OSPICE	AT MERCY		
H	27. MANNER OF DEATH Netural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME INJU		URY AT	28d. DESCRIBE HOW	INJURY OCCUR	ED		
B	2 Accident investigation				rES 2 NO					
0	3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF tNJURY - building, atc. (Specif	— At home, ferm, st fy)	reet, factory, offic	•	28f. LOCATION (Street City or Town, State	and Number or I)	Pural Route Number,		
COMPLET	an organiza									
MP	(Check only CERTIFYING PHY	SICIAN: To the best of my knowle								
8		ER: On the basis of axamination	and/or investigation	i, in my opinion, d	eath occured at the	time, date end place, as	nd due to the ca	suse(s) and manner ea stated.		
BE	29b. SIGNATURE AND TITLE OF CERTIFII	Denno men			29c. LICENSE NUI	WBER 10480	29d. DATE SI	IGNED (Month, Day, Year)		
2	30. NAME AND ADDRESS OF PERSON W	HO COMPLETED CALLSE OF DEA	TH (ITEM OT) (To-	Orint) 4		700		1/2/95		
	FERNANDO J.	FERRO, MD	THE REST (TYPE, I	1340		10 21206				
	NOV 0 7 1995	REGISTRAR'S SIGNA	THE LANGE							



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be netified at once.

•	FOR STATE REGISTRAR	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL	HYGIENI
		CERTIFICATE OF DEATH	REG. NO.

	1 - STATE REGISTRAR	SIAIE UF N	MARYLAND /	RTIF	ICATI	T OF H E OF	DEAT	AND M	IENTAL HYGIE REG. N			
-	1. DECEDENT'S NAME (First, MICHIGIN, Last) MARGARET ANN SHIREY 2. DATE OF DEATH MONTH DAY OCT 27 1995 0039 AM											
OR	168-34-7007 1□M2KF		6. AGE (In yrs. lest	birthday) YRS.	IF UNDER	DAYS	IF UNDER	24 HRS. MIN.	7. DATE OF BIRTH (Month, Day, Year) May 12,	1943	8. BIRTH Countr Bed	PLACE (State or Foreign
	9a. FACILITY NAME (If not institution Frederick Me	ital				N OR LOCATION OF DEATH			9c. CO	9c. COUNTY OF DEATH Frederick Co.		
DIRECTOR	RESIDENCE OF DECEDER 10a. STATE 10b. C		10c, CIT	Y, TOWN	OR LOCAT	ION					10d. INSIDE CITY	
	Md. FI		Knoxv								1 TES 2 NO	
FUNERAL	P. 0. Box 2		101. ZIP CODE 21758						10g. CI	U S	A	
B⊀	19. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	T EVER IN U.S. ARM YES 2 NO	YES 2 NO If yes			DECENDENT OF HISPANIC ORIGIN? (Spe., specify Cuban, Maxican, Puerto Rican, YES 2 (\$\mathbb{X}\$ NO Specify:			fes or No	es or No— 14. RACE — American Indien, Black, White, etc. Specify: White		
COMPLETED	15. DECEDENT' (Specify only highes Elementary/Secondary (0-12)	(Give	18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Assistant Mgr.				g	166. KIND OF BUSINESS/INDUSTRY Restaurant				
ш	17. FATHER'S NAME (First, Middle, La Albert McDo	*							E (First, Middle, Meid			
10 B	19a. INFORMANT'S NAME (Type/Print	*	19b.						oute Number, City or 1			
	Jacqueline A. 20a. METHOD OF DISPOSITION		20b. PLACE AT	ND DATE	OF DISPOS	SITION /Na	me of		DATE 20c. LOCATION - City or Town, Stata			wn. Stata
	1 Burlai 2 Cremation 3 4 Donation 8 Other (Specify)	Smith	natory or o	ther place)	rema	tory		11/1 Sm	ithsb	urg,	Md.
	21. SIGNATURE OF FUNERAL SERV		CC. Fields 22. NAME AND ADDRESS OF FACILITY Jefferson Chapel Funeral Home P. 0. Box 838, Charles Town, W.						25414			
CERTIFICATION	shock, or heart fellure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, it any, leading to immediate cause. Enter UNDERLYING CAUSE. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):									Interval Between Onset and Death		
MEDICAL C	PART II. Other eignificant conditions contributing to death but not resulting in the									N AUTOPSY ORMED?		WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?
PHYSICIAN: N	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 28. PLACE OF OEATH (Check only one)											
YSIC	1 K YES 2 NO	HOSPITAL: 1 Inpetient 2	ER/Outpatient 3	DOA	OTHER 4 Num		5 K Rec	sidence 8	Other (Specify)			
ВУ РН	27. MANNER OF DEATH 1 1 Natural 5 Pending 2 Accident Investign	M t YES 2 NO				26d. DESCRIBE HOW INJURY OCCURED						
_	3 Suicide 6 Could n 4 Homicide determin	ome, tarm, street, factory, office					261. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
COMPLETED	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) end manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, end due to the cause(s) and manner as stated.											
TO BE (296. SIGNATURE AND TITLE OF CERTIFIER 296. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, D 09867 D 09867 D 07 27											
	52 Thomas Solyson DA Frederick MS 2,702											
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DIRECTOR: After the hours after death w

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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH YEAR STUPRICH SCAR OCT. 31 4:46 PM 1995 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year, IF UNDER 1 YEAR 6. BIRTHPLACE (State or Foreign Country) IF UNDER 24 HRS. 1 X M 2 - F 47 MARYLAND 217-50-0389 JAN. 29, 1948 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH HOPKINS DIRECTOR BALTIMORE BAYVIEW n.C. BALTIMORE CITY RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MD. BALTIMORE BALTIMORE CIT 1 X YES 2 | NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? N. HAVEN 142 ST 21224 U.S. A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 □ NO IF YES, GIVE WAR OR DATES 14. RACE — American Indian, Black, White, atc. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-if yes, specify Cuben, Maxican, Puerto Rican, atc.) 1 Never Married 2 Married 1 YES 2 DE'NO Specify. Specify: BY 3 Widowed 4 Divorced 11/67 - 10/70 WHITE COMPLETED 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY ntary/Secondary (0-12) College (1-4 or 5+) PAINTER PAINT CONTRACTING once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname, OSCAT STUPRICH notified at YNKNOWN BE 19a. INFORMANT'S NAME (Type/Print) 19h MAILING ADDRESS (Str imber or Rural Route Number, City or Town, Stete, Zip Code; 2 KENNY WHITE 2425 FLECT BALTO. MD. 21224 20b. PLACE AND DATE OF DISPOSITION (Name o 20c. LOCATION - City or Town, State DATE er place) Crematory 11/7 TRI CATONSVILLE 4 Donation 5 Other (Specify) MD. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY CONNELLY FUNERAL HOME 7110 Sollers Point & OF BUNDALK 21222 23. PART I. Enter the disease, or complications that coused the death Do enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or head fa liure. List only one cause on each line. interval Between IMMEDIATE CAUSE (Final Onset and Death Carcinoma disease or condition_ astat resulting in deeth) CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF). that initiated eventa resulting in death) LAST PART II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL PERFORMED? AMULABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO 1 YES 2 NO PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one HOSPITAL OTHER 1 X YES 2 NO 1 ☐ Inpettent: ※XER/Outpettent: 3 ☐ DOA 4 Nursing Home 5 Rasidence 6 Other (Specify) 0 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 26c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked, 1 Netural
2 Accident 5 Pending investigation 1 YES 2 NO BY 26e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 3 Sulcida 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be COMPLETED item 28 4 Homicide CERTIFYING HYSICIAN: To the best of my knowledge, death occurred at the time, data and placa, and due to the cause(a) and manner as stated. TO THE FUNERAL DE filed within 72 h 2X X MEDICAL EXAM death occured at the time, data and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) NOVEMBER 7,1995 O.C.M.E. 9 PLETED CAUSE OF DEATH (ITEM 27) 30, NAME AND 4

111 Penn Street, Baltimore, Maryland 21201

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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 -CERTIFICATE OF DEATH REG. NO. ROBERT P. SEWARD 3. TIME OF DEATH 2. DATE OF DEATH 7:25 pm " EWAR-P LOBER1 SOCIAL SECURITY NUMBER 6. AGE (In yrs. lest birthday) BIRTN 1-30-25 B. BIRTNPLACE (State or Foreign Country) IF UNDER 1 YEAR IF UNDER 24 HRS. 216-14-4840 (10 m) 301. 100) Md. 9c. COUNTY OF DEATH 96. CITY, TOWN OR LOCATION OF DEATH margland DIPECTOR and RESIDENCE OF DEC 10a. STATE 18c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Monkton Mary land 1 YES 2 NO FUNERAL 10s. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? Parce 12090 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 12 YES 2 NO IF YES, GIVE WAR OR DATES WW-II WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea or No-It yea, specify Cuban, Mexican, Puerto Rican, etc.)
 U YES 2 NO Specify: 11. MARITAL STATUS 1 Never Married 2 Married White BY 3 Widowed 4 Divorced COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Elementary/Secondary (0-12) 12 Agent Insurance 17. FATHER'S NAME (First, Middle, Lest) 18. MOTHER'S NAME (First, Middle, Maiden Surname, Seward Ashbury Horace Greelev Emma Powel. BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 16422 J.M. Pearce Rd. Monkton, Md. 21111 Mrs. Doris R. Seward 20s. METHOD OF DISPOSITION
1 □ Burial 2 1 Cremetion 3 □ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE Hilltop Service Corp. 11/4/95 Timonium, Md. 4 Donation 6 Other (Specify) 21. BURNAZURE OF FUNERAL GERVICE LIGERSEE 22. NAME AND ADDRESS OF FACILITY
Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart fallure. List only one cause on each line. Interval Between Onset and Death IMMEDIATE CAUSE (Finel Sepsis

Due to (or as a consequence of): disease or condition resulting in death) DAY Mediastinitis CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) If any, leading to immediate cause, Enter UNDERLYING Coronary artem alsease CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF) that initiated eventa Chronic reculting in death) LAST pul monan PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a, WAS AN AUTOPSY 245 WERE AUTOPSY FINDINGS MEDICAL AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? PERFORMED? 1 TES 2 NO 1 YES 2 NO 28. PLACE OF DEATH (Check only one) DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINERA 1 YES 2 HOSPITAL: OTHER Inpetient 2 ER/Outpetient 3 DOA 4 ☐ Nursing Nome 5 ☐ Residence 6 ☐ Other (Specify) 27. MANNER OF DEATH 26a. DATE OF INJURY 28c. INJURY AT 284. DESCRIBE HOW INJURY OCCURED 26b. TIME OF INJURY 1 Netural 2 Accident 5 Pending Investigation М 1 YES 2 NO BY 26a. PLACE OF INJURY — At home, term, street, factory, offica building, atc. (Specify) 261. LOCATION (Street and Number or Rural Route Number, City or Yown, State) 3 Sulcide 6 Could not be COMPLETED 4 Nomicide determined 29a. CERTIFIER CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and menner as stated. MEDICAL EXAMINER: On the basis of examination and/or restigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and menner as stated. Wen her 29b. SIGNATURE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE Resident 95 2 6 3 ₹ 2 ADDRESS OF PERSON WHO DOMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) South home

AEGISTRAR'S SIGNATURES

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BALTIMORE, MARYLAND 21215-0020

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FOR

O THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. O THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. MPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
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	FOR STATE REGISTRAR	STATE OF MARYL		RTMENT OF		MENTAL HYGIENI REG. NO.	E 90	33310		
	1. DECEDENT'S NAME (First, Middle, Lest) LAYFETT SANDRAS		T	ERRY	SR.	2. DATE OF DEATH MONTH DA NOVEMBER 2	, 1995	3. TIME OF DEATH 6:33 P. M		
BE COMPLETED BY FUNERAL DIRECTOR	4. SOCIAL SECURITY NUMBER 227-46-5194	5. SEX 6. AGE	(In yrs. last birthday) 58 YRS.	# UNDER t YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Morith, Day, Year) 01-18-1937	Cou	THPLACE (State or Foreign ortry) GINIA		
	9e. FACILITY NAME (If not institution, give street and number) NORTH ARUNDEL HOSPITAL			95. CITY, TOWN OR LOCATION OF DEATH GLEN BURNIE				Sc. COUNTY OF DEATH ANNE ARUNDEL		
	PRESIDENCE OF DECEDENT 10a. STATE 10b. COUNT MARYLAND	10c. CIT	10c. CITY, TOWN OR LOCATION GLEN BURNIE			10d. INSIDE CITY LIMITS? 1 YES 2 K				
	100. STREET AND NUMBER 9 EUGENIA AVENUE			01. ZIP CODE 21061		10g. CITIZEN OF WHAT COUNTRY?				
	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 YES IF YES, GIVE WAR OR D	I IN U.S. ARMED 13. WAS DECENDENT OF HISPAN 1 yes, specify Cuban, Maxica			IIC ORIGIN? (Specify Yes n, Puerto Rican, etc.)	CE - American Indian, ack, White, etc. ec/ly: WHITE			
	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) CUSTODIAN			22000	16b. KIND OF BUSINESS/INDUSTRY P.G. COUNTY				
	17. FATHER'S NAME (First, Middle, Last) GARNETT T			18. MOTHER'S NAME (First, Mick LUCY			e, Malden Surname) DAVIS			
TO B	190. INFORMANT'S NAME (Type/Print) BILLIE JEAN TERRY	7				Route Number, City or Town BURNIE, M		1		
	20b. PLACE AND DATE OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of CLEN BURNIE, MD. 1/6/9 20c. LOCATION - City or Town, State 20c. L									
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, indeed to heart feliure. Liet only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE/TO (OR AS A CONSEQUENCE OF):									
AN: MEDICAL CERTIFICATION	Sequentially list conditions, if any, leading to immediate couse. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. OUE TO (OR AS A CONSEQUENCE OF): C. SUMUL OLAS OF CONSEQUENCE OF): d. UNDUC Propressive Development demonstrated and the consequence of the country of the consequence of the country of the c									
	PART II. Other significent condition	PERFOR	24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 MO 24b. WERE AUTOPSY FIND AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?							
	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 28. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one)									
PHYSICIAN:	EXAMINER? 1 YES 2 NO									
ВУ РН	27. MANNER OF DEATH t Natural 5 Pending 2 Accident Investigation	(Morth, Day, Year)	IN	b. TIME OF 186: INJURY AT 28d. DESCRIBE HOW WORK? 1 YES 2 NO			/ INJURY OCCURED			
	3 Suicide 8 Could not be determined 28a. PLÂCE OF INJURY — At home, 1arm, street, 1actory, offica building, etc. (Specify) 28a. PLÂCE OF INJURY — At home, 1arm, street, 1actory, offica City or Town, State)							al Route Number,		
COMPLETED	29a. CERTIFIER (Check only of the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. ### MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated.									
BE	29b. BISSMATURE AND FITLE OF CENTIFIE		D33988				29d. DATE SIGNED (Month, Day, Year) NOVEMBER 3, 1995			
2	PATRICIA O'HARA, M.D., 1509 RITCHIE HIGHWAY, ARNOLD, MD. 21012									
	31. DATE FILED (MOOT), DRY, MAT 1995 32. REGISTBAR'S SIGNATURE Falsa of Audiencharland									

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - REGISTRAR		CERTIF	ICATE OF	DEATH	REG. NO.		
	1. DECEDENT'S NAME (First, Middle, Last) LENA GERT	ÍNAL		2. DATE OF DEATH MONTH NOVEMBER	5. 1995	3. TIME OF DEATH 12:15 A. M		
	000 01 (501		E (In yrs. last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Pay, Year) 03-16-191	a, BIRT	HPLACE (State or Foreign
TOR	9a. FACILITY NAME (If not institution, give street and number) 8 BIRCH AVENUE GLEN BURNIE ANNE ARUNDEL RESIDENCE OF DECEDENT							
DIRECTOR	10e. STATE 10b. COUNTY	E ARUNDEL	10c. CIT	Y, TOWN OR LOCAT				
BY FUNERAL	8 BIRCH AVENUE			101. ZIP CODE 21061			U.S	
BY FUI	11. MARITAL STATUS 1 Never Married 2 Married 3 X Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 YE IF YES, GIVE WAR OR	R IN U.S. ARMED S 2 NO DATES A	If yes, sp		ilC ORIGIN? (Specify Yea n, Puerto Rican, etc.)	Ble	CE — American Indian, ick, White, etc. icity: WHITE
COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade of Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind of life. Do NOT u		st of working		SINESS/INDUSTRY	ATE HOSPITAL
OMP	1.2	N/A	SEAMSTR	ESS/INST		ME (First, Middle, Maiden		ATE HOSFITAL
BE CO	WILLIAM		MANGUM		HATT		LOOPER	
10 B	19a. INFORMANT'S NAME (Type/Print) WANDA L. TRIMNAL					BURNIE, M.		21061
	20a. METHOD OF DISPOSITION 1 To Buriel 2 Cremation 3 Remove 4 Donation 6 Other (Specify)	rel from State	60b. PLACEAND DATE emetery, cremetory or C GLEN HAVE	ther place!		11/7/1995	CATION — City or	Town, State
	21. SIGNATURE OF JUNERAL SERVICE LICE		JEN HAVE	22. NAME A	ND ADDRESS OF FA	CILITYSINGLET	ON FUNER	AL HOME, E, MD.21061
	23. PART I. Enter the diseases, or co shock, or heart failure. Li	mplications that caus at Only one cause on	ed the death. Do each line.	not anter tha mo	de of dying, suc	h as cardiac or reap	ratory arrest,	Approximate Interval Between
	IMMEDIATE CAUSE (Final disease of condition resulting in death) Due to (or as a consequence of):							Onset and Desth
NO	Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF):							
CATI	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury							
CERTIFICATION	that Initiated events resulting In death) LAST	DUE TO (OR AS	S A CONSEQUENCE O	PF):				
DICAL C	PART II. Other significant conditions	contributing to death	but not resulting	in the underlyin	g cause given in	Part I. 24s. WAS AN PERFOR		No. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO
I III I						1 TYES 2	DATO -	OF DEATH?
IN: M	DID TOBACCO USE CONTR	BUTE TO CAUSE				N 🗆		х
SICIAN:		HOSPITAL:		OTHER:		6 Other (Specify)		*
PHY	27. MANNER OF DEATH	28a. DATE OF INJUR (Month, Day, Year	Y 28b. TII	/E OF 28c. IN.	JURY AT DRK?	28d. DESCRIBE HOW	NJURY OCCURED	
BY	1 New State	28e. PLACE OF INJU	RY — At home, farm,		YES 2 NO	281, LOCATION (Street	and Number or Burn	d Shute Number
밀	3 Suicide 6 Could not be 4 Homicide datarmined	building, atc. (S	pecify)	actory, other		City or Town, State)		route rumper,
COMPLET	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICI MEDICAL EXAMINER	IAN: To the best of my kn						e(a) and manner ea stated.
BE C	29b. SIGNATUHI AND TITLE OF CERTIFIER		T	\rightarrow	29c. LICENSE NUI	MBER O	29d. DATE SIGNI	ED (Month, Day, Year)
욘	30. NAME AND ADDRESS OF PERSON WHO	DIMPLETED CAUSE OF	DEATH (ITEM 27) (Typ	e, Print)	D D	- 08	-11)1
				in hwy	,#306,	Glen Buri	nie, Md	. 21061
	NOV 0 71995	32. REGISTRAR'S SI	UNATURE					

	FOR 1 - STATE REGISTRAR	STATE OF MARYLAN	ND / DEPARTM			MENTAL HYGIEN	_	
,	1. DECEDENT'S NAME (First, Middle, Last)	= 1/-1-						3. TIME OF DEATN
		TRABERT SEX 8. AGE (In)	yrs. last birthday) IF	UNDER 1 YEAR	IF UNDER 24 HRS.		25 190	25 Z, Z4 P M BIRTNPLACE (State or Foreign
8		□ M 2 🖒 F 79		THS DAYS	HOURS MIN.	(Month, Day, Year) FEB. 3,19	916	JARYLAND
	9e. FACILITY NAME (If not Institution, give stree			4 /	R LOCATION OF DE	ATN	De COUNTY	OF DEATH
DIRECTOR	MORTH FIRUNGEL	Hospiti	AL IC	TIEN	BURN	IE	HNN	EARUNDEL
REC	10a. STATE 10b. COUNTY	ADUNDEL		OWN OR LOCAT				10d. INSIDE CITY LIMITS?
	MARYLAND ANNE	ARUNDEL	GLE	N BURN	ZIP CODE		10a CITIZEN	1 YES 2 X NO
FUNERAL	366 KLAGG COURT AI	PT. 204			21061		USA	
N N	11. MARITAL STATUS 1 Never Married 2 Married	2. WAS DECEDENT EVER IN U FORCES? 1 YES		It yes, spe	cify Cuban, Maxica	IIC ORIGIN? (Specify Yen, Puerto Rican, atc.)	or No- 14.	RACE — American Indian, Black, White, atc.
B	3 X Widowed 4 Divorced	IF YES, GIVE WAR OR DATE	ES	1 TYES	2 NO Specify	r.	1	Specify:
COMPLETED	15. DECEDENT'S EDUCAT (Specify only highest grade co	TION 1	6a. DECEDENT'S USU (Give kind of work life. Do NOT use re	done during mos	N st of working	16b. KIND OF BU	SINESS/INDUST	TRY
PE	Elementary/Secondary (0-12)	College (1-4 or 5 +)	INSPECT	,		FACTO	RY	
NO.	17. FATHER'S NAME (First, Middle, Last)			011	18. MOTHER'S NA	ME (First, Middle, Maiden		
BE (WILLIAM A 194. INFORMANT'S NAME (Type/Print)	CARSO				LOTTE	BUH	
2	CLAUDIA LEE TRABER	T				Poute Number, City or Tow 204 GLEN B		
	20a, METHOD OF DISPOSITION 1 X Burtal 2 Cremation 3 Remove		LACE AND DATE OF D	ISPOSITION (Na	me of		CATION — City	
	4 Donation 5 Other (Specify)	Gl	EN HAVEN		ERY ID ADDRESS OF FA	11/15/95	GLEN BI	URNIF MD.
	· Dil	Lity-1	•	STALL	INGS FUNI	ERAL HOME		
-	23. PART i. Enter the diseases, or cor	and the second	the deeth. Do not	3111 [Mountain de of dying, suc	Road Pasa h ea cardiec or reep	dena Mi	aryland 21122
	shock, or heart fellure. List IMMEDIATE CAUSE (Final	it only one course on esc	th line.	0:0	/	(.		Interval Between Onset and Death
	disease or condition resulting in death)	HCUSE DUE TO (OR AS A C	Myo Car	eliof	rufar	ction		10 hours
_		Dials	EXE [Me	elitics.			
<u> </u>	Sequentielly list conditions, if any, leading to immediate	DUE TO (OR AS A C	CONSEQUENCE OF):					
	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	DUE TO TOR AND O	CONSEQUENCE OF):	m				
CERTIFICATION	reaulting in death) LAST							
AL CI			lesth but not resulting in the underlying cause given in Part i.					24b. WERE AUTOPSY FINDINGS
EDICA	bleemonary	edema				PERFO		AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
Σ	DID TODA CCO LICE CONTROL	DUTE TO CALLEE OF	DEATH VEC		LINICEDTAL			1 TYES 2 NO
PHYSICIAN:	DID TOBACCO USE CONTRII		DEATH TES		UNCERTAIN	N LJ		
SIC	EXAMINER?	HOSPITAL: Ompatient 2 ER/Output	tlent 3 DOA 4	THER:	s 5 Realdence	6 Other (Specify)		
	27. MANNER OF DEATH 1 Netural 5 Pending	26a. DATE OF INJURY (Month, Day, Year)	28b. TIME O	/ Wo	URY AT PRK? YES 2 NO	28d. DESCRIBE HOW	INJURY OCCUR	ED
D BY	2 Accident Investigation 3 Suicide 6 Could not be	28e. PLACE OF INJURY -				28t. LOCATION (Street City or Town, State	and Number or	Rural Route Number,
III.	4 Homicide determined	building, atc. (Specify				City or lown, State		
4 Homicide determined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the beat of my knowledge, death occurred at the time, data and place, and due to the cause(a) and many one) 2 MEDICAL EXAMINER: On the beat of examination and/or investigation, in my opinion, death occurred at the time, data and place, and the cause (a) and many one)								
	29b. SIGNATURE AND THIS OF CERTIFIER	On the beside of examination	and/or investigation, i	n my opinion, d	29c. MCENSE NUI		_	suse(a) and manner as stated.
) BE	allin	Vhee 6	~		7) 3	1122	D 11	15/85
7	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEAT	TH. (IYEM 27) (Type, Pri	(The	cure -	Scut 200	Gleu	Bernix MD
	NOV 0 71995	22. REGISTRAR'S SIGNAT	TURE /					21061

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BALLIMORE, MARTLAND 21213-0020	hours after death. Page 6 may be retained by the hospital or attending physician.	certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 88760	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burfal, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	FOR STATE REGISTRAR	STATE OF MARYLA		RTMENT OF		MENTAL HYGIEN	E	
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH
	Americo E	dward		VESPUCC	I	November 2		8:24 pM
,	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (II	n yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRT	HPLACE (State or Foreign
	177-22-5725 90. FACILITY NAME (If not institution, give str		7 YRS. MONTHS DAYS HOUPS MIN. Sept. 14,1928 Pennsylvani 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH					
O.B	Franklin Square Hospital				altimore	LAIN	Balt:	
ᇤ	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		10c, Ci	TY. TOWN OR LOCA	TION			10d. INSIDE CITY
FUNERAL DIRECTOR	Maryland Baltimore				ltimore			LIMITS?
₹ I	10e. STREET AND NUMBER			11	H. ZIP CODE			WHAT COUNTRY?
	3903 Mewswood C				21236		U.S.	Α.
5	tt. MARITAL STATUS t Never Married 2 Married	12. WAS DECEDENT EYER IN FORCES? 1 X YES	U.S. ARMED			NIC ORIGIN? (Specify Yes an, Puerto Rican, etc.)	or No — 14. RAG	CE — American Indian, ck, White, etc.
BY	3 XWidowed 4 Divorced	IF YES, GIVE WAR OR DA	TES		S 2 NO Speci		Spe	ofly:
	t6. DECEDENT'S EDUC	1947-1950	44 DECEDENT	2 1101141 0001101		The same property		White
COMPLETED	(Specify only highest grade	completed)	(Give kind of life. Do NOT i	S USUAL OCCUPAT work done during in	ION ost of working	16b. KIND OF BUS	BINESS/INDUSTRY	
2	12th grade	College (1-4 or 5+)	Labor	,		Wareh	01100	
× I	17. FATHER'S NAME (First, Middle, Last)		Labor	. C.L	40 MOTHER'S N	AME (First, Middle, Maiden		
ö	Edward Vespucc	i			Carme			
BE	19a. INFORMANT'S NAME (Type/Print)	1	10h MAN IN	C ADDRESS (Street		Route Number, City or Town		
2		aughter)				. A-l, Balt		m 21236
							CATION — City or	
	20a, METHOD OF DISPOSITION 1 M Burlal 2 Cremation 3 Remo	oval from State	atery, crematory or	OF DISPOSITION (I	rame or	ensl1/6 Ti	CATION — City or	Managa I am J
	21. SIGNATURE OF FUNERAL SERVICE LIC	FNSFF	llaney v	arrey Me	ND ADDRESS OF F	ensii/p iii	monium,	матутапо
	//	111				neral Home	s, Inc.	
	The ha	III		9705	Belair H	Rd., Baltim	ore, MD	21236
	23. PART Phter the diseases, or c	omplications that caused	the deeth. Do	not enter the m	ode of dying, au-	ch aa cardiac or reapi	ratory arreat,	Approximata
							Onset and Death	
	disease or condition							5 days
ľ	resulting in death) a. Hypoxic Brain Damage Due to (or as a consequence of):							
z	Atherosclerotic Cardiovascular Disease							
2	Sequentially list conditions, oue to (or as a consequence of): If any, leading to immediate							
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or Injury	D						
별	that initiated eventa resulting in death) LAST	OUE TO (OR AS A	CONSEQUENCE	OF):				
H	resulting in death) Exs.	d						
AL C	PART ii. Other aignificent condition	s contributing to death b	ut not resulting	In the underlyi	ng ceuse given in	Part I. 24s. WAS AN	AUTOPSY 24	b. WERE AUTOPSY FINDINGS
8	Sepsis					PERFOR	222	AVAILABLE PRIOR TO COMPLETION OF CAUSE
	DEPSIS					1 🗆 YES 2	XMo	OF DEATH?
Σ	DID TOBACCO USE CONTI	DIDLITE TO CALISE O	E DEATH V	ES T NO I	Z LINICEDTA	INI D	- 1	t TYES 2 NO
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL			ATH (Check only on				
2	EXAMINER?	HOSPITAL:		OTHER:				
ΙŻ	1 YES 2 NO	t X Inpatient 2 ER/Outp	atlent 3 DOA			8 Other (Specify)		
	1 Netural 5 Pending	(Month, Day, Year)		JURY V	JURY AT ORK?	28d. DESCRIBE HOW I	NJURY OCCURED	
B	2 Accident Investigation	00- DI 105 05 III IIIDI			YES 2 NO	ļ		
COMPLETED	3 Suicide 6 Could not be determined 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28e. PLACE OF INJURY — At home, farm, street, factory, office City or Town, State)					I Floute Number,		
4	29a. CERTIFIER	CIAN: To the best of my knowl	ladge death occur	rod at the time de	o and place and di-	a to the council and	anne en elektrik	
ž.	cool only	R: On the besis of examination						(a) end manner as stated.
8	29b. SIGNATURE AND TITLE OF CERTIFIER							
H	Wind to a si	1			29c. LICENSE NU		29d. DATE SIGNE	3 9 S
2	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUSE OF DE	ATH /ITEM OT /T-	na Print!	P082	49	7 14	3/ -13
			. , , , , ,	,	dans D	1.4	1 1	21227
	Fiona Wilson, M. 31. DATE FILED (Month, Day, Year)	D. 9000 Fra		quare Dr	ive Ba	ltimore, Ma	ryland	21237
	NOV 0 71995 A	la Divelor Re	1. II					
	11000	Will be seen to be seen to be	T.B.M.					

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detached for use as the burial-transit permit. Pages 1, 2, 3 should

DIRECTOR

FUNERAL

BY

COMPLETED

BE

9

CERTIFICATION

MEDICAL

PHYSICIAN:

BY

COMPLETED

BE

2

1 Natural

2 Accident

3 Suicide

4 Homicide

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within

DIRECTOR: A hours after d 28 is

TO THE HOSPITAL OF TO THE FUNERAL DI DE filed within 72 ho IMPORTANT: If Its

Hem

this certificate has been si	rked,
After	в ша

page 5 should be

attending physician and completely filled in by the

ITEM: 9b. PER F.H. FILM G-729 11/7/95 t.t STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 1995 12:37 Am Johnnie Watson October 29 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign 5 SEY AUG. 10, 1918 251-07-0271 77 MONTHS DAYS HOURS 1 🔀 M 2 🗌 F ANDREWS. S.C. 9a. FACILITY NAME (If not institution. 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 6208 PLYMOUTH ROAD BALTIMORE -CTIY CITY n/a RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10a, STATE 10d. INSIDE CITY MARYLAND n/a BALTIMORE 1X YES 2 NO 10e. STREET AND NUMBER 10t, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 6208 PLYMOUTH ROAD 21214 UNITED STATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—
It yee, specify Cuben, Maxican, Puerto Rican, etc.)
1 YES 2 XX0 Specify: 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1XX YES 2 □ NO IF,YES, GIVE WAR OR DATES 11. MARITAL STATUS 14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married Specify: 3 X Widowed 4 Divorced unknown 16s. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of life. Do NOT use retired.) 15 DECEDENT'S EDUCATION 165 KIND OF BUSINESS/INDUSTRY (Specify only highe Elementary/Secondary (0-12) College (1-4 or 5+) th CABLE CUTTER C.V. FOSTER EQUIPMENT CO. 6 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First Middle Malden Surneme) FREDERICK WATSON REELY BREWINGTON 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) LILA STEWART WEBB COURT, BALTIMORE, MD 20s. METHOD OF DISPOSITION
XX Burlai 2 Cremation 3 Ramoval trom State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, Stata AUBURN CEMETERY BALTIMORE, MARYLAND ☐ Donation 5 ☐ Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY WM. C. MARCH FH.-1101 E. NORTH A VENUE 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haert fellurs. Most only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in deeth) Immobility DUE TO (OR AS A CONSEQUENCE OF): Accident Cerebrovascular Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if sny, leading to immediate COURSE Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): thet initiated events resulting in deeth) LAST PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY Metastatic Prostate Carcinoma, Recurrent Urinary 1 YES 2 THO Tract Infection, Greenfield filter, Deep Venous Thrombosis DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) HOSPITAL:
1 | Inpetiant 2 | ER/Outpetiant 3 | DOA 4 Nursing Home 5 Rasidence 6 Other (Specify) 1 X YES 2 NO 27, MANNER OF DEATH 28a. DATE OF INJURY 28d, DESCRIBE HOW INJURY OCCURED

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO

Interval Between Onset and Death

6 wouths

28c. INJURY AT WORK?

1 YES 2 NO

28a. PLACE OF INJURY — At home, larm, street, factory, office building, atc. (Specify) 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER

The color of the cause (a) and manner as stated.

2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(e) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER

y famos. M.D.

investigation

8 Could not be

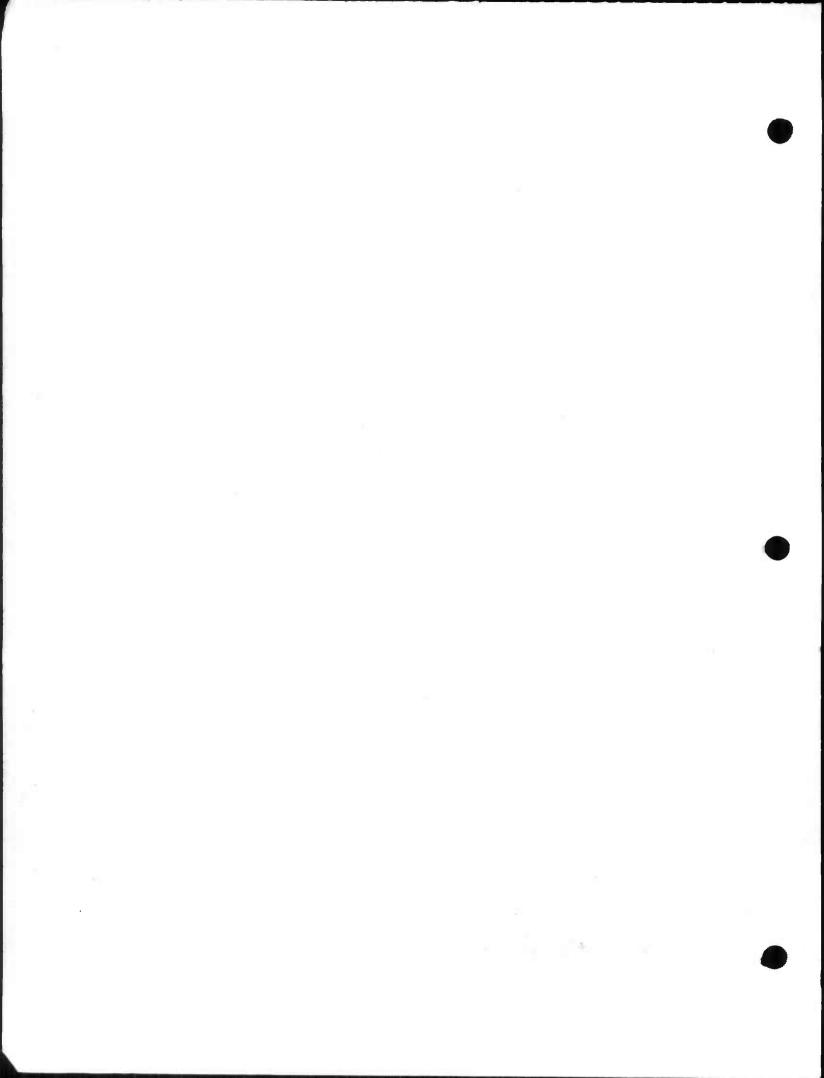
D32548

29d, DATE SIGNED (Month, Day, Year)

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
PERRY L. Colvin, MD. Baltimore VA Med Cutr, 10 N. Greene St., Balt. MD 21201 PERRY L. Colvin, MD.

31. DATE FILED (Month, Day, Year)

A. REGISTRAR'S SIGNATURE



3. TIME OF DEATH

REG NO.

2. DATE OF DEATH

STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Lest)

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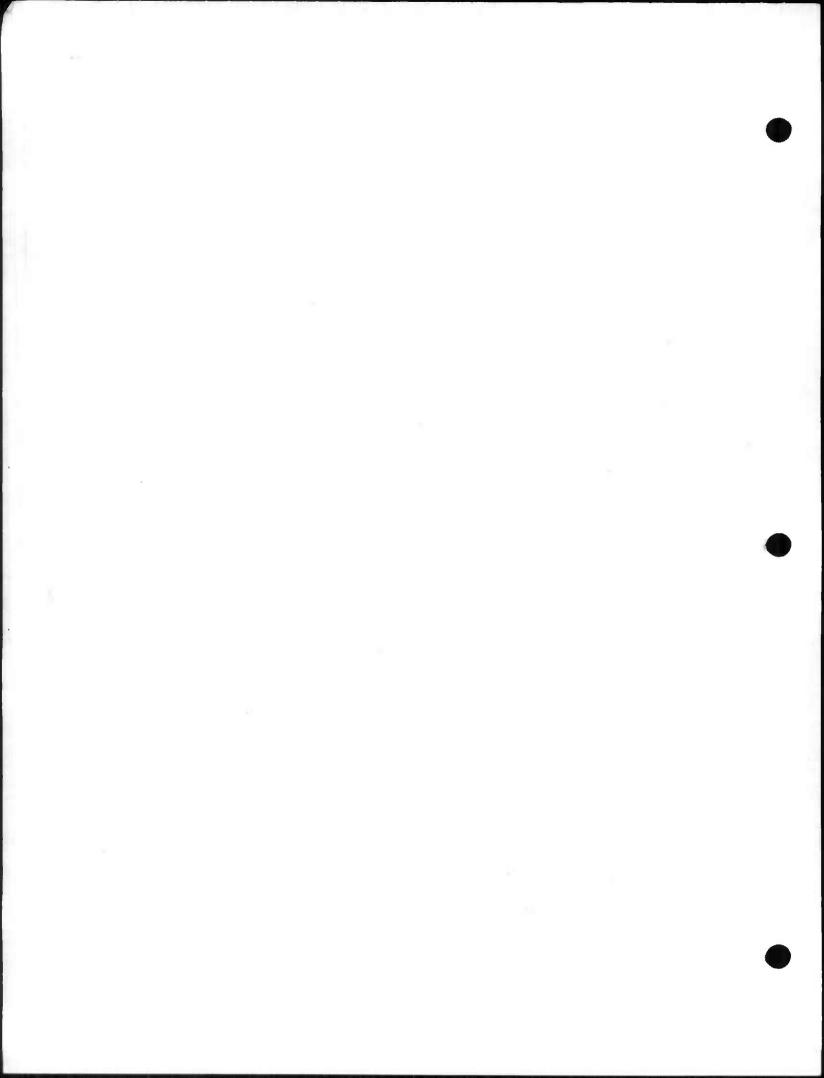
NOVEMBER 3, 1995 6AM BEULAH В. WYATT 7. DATE OF BIRTH
(MOTH), Day, Ybar)
JUNE 1, 1925 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign WEST VIRGINIA DAYS 1 M 2 F 70 578-72-4635 the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR ANNE ARUNDEL 237 LIST AVE. PASADENA 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY ANNE ARUNDEL MARYLAND **PASADENA** 1 YES 2 NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 18g. CITIZEN OF WHAT COUNTRY? 237 LIST AVE 21122 USA within 24 hours after death. Page 6 may be retained by the hospital or attending physician. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or Noif yes, specify Cuban, Maxican, Puarto Rican, atc.)

1 YES 2 NO Specify: 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 14. RACE - American Indian, Black, White, atc. FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 1 Never Married 2 X Married Specify BY 3 Widowed 4 Divorced WHITE ED 15. DECEDENT'S EDUCATION 18a. DECEDENT'S USUAL OCCUPATION 16h. KIND OF BUSINESS/INDUSTRY (Specify only highest grade completed) (Give kind of work done life. Do NOT use retired.) H Elementary/Secondary (0-12) College (1-4 or 5+) **FDITOR** COMPL GODDARD SPACE CENTER notified at once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malden Surname) ROBERT **BROWN** LEWEY MARGARET L. GENTRY 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zio Code) 2 ROBERT S. AVE. PASADENA. MARYLAND 21122 WYATT 37 LIST pe 20s. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must JAMES CEMETERY 11/6/95 LOTHIAN MARYLAND examiner 21. SIGNATURE OF FUNERAL SHAVES LICENSES 22. NAME AND ADDRESS OF FACILITY ▶ Hiland STALLINGS FUNERAL HOME P.A. stal Lings 3111 Mountain Road Pasadena, MD 21122 medicai 23. PART I. Enter the dieeeses, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, filled in by Approximate shock, or heert fellure. List only one Interval Between Onset and Death IMMEDIATE CAUSE (Final the RESPIRATORY
DUE TO (OR AS A CONSEQUENCE OF) disease or condition FAILURE Month completely resulting in death) traumatic event, executed bunal, GMPHYLGMA ear and CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): prior to if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury the attending physician Mental Hygiene prior to other DUE TO (OR AS A CONSEQUENCE OF): that initiated events reaulting in death) LAST 0 injury, PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS MEDICAL signed by t AVAILABLE PRIOR TO shows any COMPLETION OF CAUSE has been signed to bept, of Health a 1 TES 2 2.00 1 TES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN D PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Hem certificate State HOSPITAL: OTHER 1 | YES 2 | 10 1 | Inpetient 2 | ER/Outpetient 3 | DOA ATTENDING PHYSICIAN: 6 with the 27. MANNER OF DEATH 26c. INJURY AT WORK?

1 YES 2 NO 26s. DATE OF INJURY (Month, Day, Year) 26d. DESCRIBE HOW INJURY OCCURED marked, this 1 Netural 5 Pending Investigation BY After 2 Accident after death 28s. PLACE OF INJURY — At home, ferm, street, fectory, office building, atc. (Specify) 3 Suicide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28 is I COMPLETED DIRECTOR 4 Homicide TO THE HOSPITAL OR ATT TO THE FUNERAL DIRECT be filed within 72 hours at IMPORTANT: If Item 2 29s. CERTIFIER
(Chack only)
1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the ceuse(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Day, 29c. LICENSE NUMBER BE Townsha trugin D21776 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) NO PATARICO AV. SACTIMONE MUNDRAMO 31. DATE FILED (Month, Day, Year) NOV 0 7 1995 3. REGISTRAR'S SIGNATI DHMH-16 Rev 1/89

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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TO THE HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1. 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

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	FOR STATE REGISTRAR	STATE OF MARYL		TMENT OF H		NTAL HYGIEN REG. NO.	E	
	1. DECEDENT'S NAME (First, Middle, Last)	_	Α.		2	DATE OF DEATH		3. TIME OF OEATH
	DOROTH	Y E.	h	10005	C	CLOBER	31 . 199	85 11.11 AM
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE	(in yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS. 7	DATE OF BIRTH (Month, Day, Year)	8.	BIRTHPLACE (State or Foreign Country)
- 8	213-20-6201	1 🗆 M 2 🔀 F	80 YRS.	MONTHS DAYS		pril20,19		Maryland
اہا	9a. FACILITY NAME (If not institution, give s				R LOCATION OF DEAT	Н	9c. COUNTY	OF DEATH
0	Harbor Hos	pital		Baltir	nore City			
[H	10a. STATE 10b. COUNT	Υ	10c. CIT	Y, TOWN OR LOCAT	ION			10d. INSIDE CITY
DIRECTOR	Maryland Anne	Arundel	Pa	asadena				LIMITS?
A	10e. STREET AND NUMBER			101	ZIP CODE		10g. CITIZEN	OF WHAT COUNTRY?
FUNERAL	1915 Orch	ard Pt. Rd.			21122			U.S.A.
5	11. MARITAL STATUS	12. WAS DECEDENT EVER II			ENDENT OF HISPANIC		or No — 14.	RACE — American Indian, Black, White, etc.
BY F	1 Never Married 2 Married 3 S Widowed 4 Divorced	IF YES, GIVE WAR OR D		1 TES	2 NO Specify:	ruanto Hican, atc.)		Specify: White
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TED	15. DECEDENT'S EDU (Specify only highest grade	completed)	(Give kind of a life. Do NOT us	USUAL OCCUPATION Work done during mo	N st of working	16b. KIND OF BU	SINESS/INDUST	TRY
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COMPLET	17. FATHER'S NAME (First, Middle, Last)		VVIICE	-1.3011	10 MATHED'S NAME	(First, Middle, Maiden		30
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BE	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADORESS (Street a	nd Number or Rural Rou			
2	Albert Woods				. Pasadena			,
	20a METHOD OF DISPOSITION	201	D. PLACE AND DATE	OF DISPOSITION (No				or Town, State
	18 Burlai 2 Cremation 3 Removal from State Cametery, Cremetory or other place Glen Haven Mem. Park Nov. 3, 1995 Glen Burnie, Maryland							
	21. SIGNATURE OF FUNERAL SERVICE LI		/	22. NAME AN	D ADDRESS OF FACIL	ITY		
	June &	8. 90gn	M					ryland 21122
	23. BART I. Enter the diseeses, or shock, or hasrt fallura.	complicatione that cause List only one cause on e	d the death. Do i	not enter the mo	de of dying, such a	a cardiec or reap	iratory arrest	Approximate interval Between
1 1	IMMEDIATE CAUSE (Final							Onset and Death
	disease or condition resulting in death)	· PN	EUMON	IIA				5 days
			A CONSEQUENCE O					- 1
No.	disease or condition resulting in death) **BUE MONIA DUE TO (OR AS A CONSEQUENCE OF): DIABETES MELLITUS DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):							
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CERTIFICATION	CAUSE (Disease or injury that initiated evants	C DUE TO (OR AS	A CONSEQUENCE O	F):				
E	resulting in death) LAST	4						
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¥	27. MANNER OF DEATH	1 Ninpatient 2 ER/Out	patient 3 DOA		e 5 🗆 Realdence 6 i	Other (Specify) Bd. DESCRIBE HOW	IN HURY OCCUR	DED.
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ВУ	2 Accident Investigation 3 Suicide Could and be	28s. PLACE OF INJURY	Y — At home, farm,			81. LOCATION (Street	and Number or	Aural Route Number,
밀	4 Homicide 8 Could not be	building, atc. (Spe	icify)			City or Town, State,		,
<u> </u>	29a. CERTIFIER CERTIFYING PHYS	ICIAN: To the heat of my know	vladas desth essum	and of the time date	and alone and death	M		
COMPLET	and a	SICIAN: To the beat of my know ER: On the basis of examination						ause(a) and menner as stated.
	296, SIGNATURE AND TITLE OF CERTIFIE	in			29c, LICENSE NUMBI	ER	29d. DATE S	IGNED (Month, Day, Year)
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[30. NAME AND ADDRESS OF PERSON WI	10 COMPLETED CAUSE OF DE				R.		0 =
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BALTIMORE

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BALTIMORE, MARYLAND 21215-0020

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DIVISION OF VITAL RECORDS, P.O. BOX 68760,

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DIRECTOR	10n. STATE MD	10b. COUNTY	Arund	el	10c. CITY 624	town of DE	eale	RO	ad,	Dea	le			10d. INSIDE CITY LIMITS? 15 YES 2 NO
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E	15. DEC	EDENT'S EDU	CATION	16a. Di	ECEDENT'S	USUAL O	CCUPATI	ON		16b.	KIND OF BUS	SINESS/INC	DUSTRY	
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10 1	19m. INFORMANT'S NAME () Patricia		en		624 I						er, City or Town	n, State, Zip		
	20e. METHOD OF DISPOSIT 1 © Burlel 2 Cremetic 4 Donetion 5 Other	on 3 🗆 Rem	oval from State	20b. PLACE cemetery, cri	and date of ematory or other James	F DISPOS	SITION (N	ame of		1 1 /	20c. LO	cation —		
Î	21. SIGNATURE OF FUNERA	L SERVICE L	CENSEE	\bigcap	0	22.	NAME A	ND ADDRE	SS OF FA	CILITY	al Ho			
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	23. PART I. Enter the d shock, or h IMMEDIATE CAUSE (Fir disease or condition resulting in death)	eart fellure.	a. DUE TO	use on each line	OUENCE OF						nac or reap	ratory an	reat,	Approximata interval Batween Onset and Daath
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ž	1 YES 2 NO		HOSPITAL:	ER/Outpatient	DOA DOA	OTHE!	R: sing Hor	10 5 🗆 R	esidence	8 🗆 Other	(Specify)	10		
		Pending Investigation	28e. DATE OF (Month, D		28b. TIMI	-	28c. IN.	PURY AT ORK?			CRIBE HOW I	NJURY OC	CURED	- 44-0
ED B	3 Suicide 8	Could not be datermined	28e. PLACE C building.	of INJURY — Al he	ome, larm, a	treet, lact	tory, offic	:0		281. LOC. City	ATION (Street a or Town, State)	and Number	r or Rural I	Route Number,
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2	30. NAME AND ADDRESS OF	F PERSON WH	O COMPLETED CAU	SE OF DEATH STE	EM 27) (Type,	Print)	P	5-	L3/	MA.		1:	ME)21/10/
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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNEAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1	be filed within 72 hours affer death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF OFATH November 2, 1995 Ezell WOMBLE 3:19 Pm ROBERT 7. DATE OF BIRTH (Month, Day, Year) June 6 1930 4. SOCIAL SECURITY NUMBER 5. SEX IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 246-36-9961 1 M 2 | F 65 Tenn. 9a. FACILITY NAME (If not institution, give 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 52 Rosepetal Ct. Baltimore Carney RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Md. Baltimore 1 - YES 2 1 NO Carney FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10a, CITIZEN OF WHAT COUNTRY? 52 Rosepetal Ct. 21234 USA 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yea, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 12. WAS DECEDENT EVER IN U.S. ARMED 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES 1 Never Merried 2 Married Specify: BY 3 Widowed 4 Divorced White Korean 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) COMPLET Elementary/Secondary (0-12) College (1-4 or 5 +) +4Salesman Industrial Products 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malden Surname) Grover C. Womble Sallie Womble 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 0 Anne Marie Womble 52 Rosepetal Ct. Carney Md. 21234 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State 20s. METHOD OF DISPOSITION

1 Burial 2 Cremation 3 Removal from State

4 Donation 5 Other (Specify) Hilltop Service Co. Nov. 4 95 Towson Md. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 23. PART I. Enter the disastes, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feliure. List only one ceuse on each line. intervai Between **Onset and Death** IMMEDIATE CAUSE (Final disease or condition MM reaulting in death) DWE TO (OR AS A CONSEQUENCE OF CERTIFICATION Sequentially list conditions, TO (OR AS A CONSEQUENCE OF if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated eventa reaulting in death) LAST PART II. Other aignificent conditions contributing to deeth but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY WERE AUTOPSY FINDINGS MEDICAL ESOPHAGUS RRESTS PERFORMED? AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\square\) NO \(\square\) UNCERTAIN \(\begin{align*} \begin{align*} \limin \limin \\ \ext{O} \ext{TO INCERTAIN } \(\begin{align*} \limin \limin \\ \ext{O} \\ \ext{ON INCERTAIN } \(\begin{align*} \limin \\ \ext{ON INCERTAIN } \\ \ext{ON INCERTAIN } \(\begin{align*} \limin \\ \ext{ON INCERTAIN } \\ \ext{ON INCERTAIN } \(\begin{align*} \limin \\ \ext{ON INCERTAIN } \\ \ext{ON INC PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER:
4 | Nursing Homa 5 | Desidence 8 | Other (Specily) 1 YES 2 700 1 | Inpatient 2 | ER/Outpatient 3 | DOA 27. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 5 Pending Investigation 1 Natural 1 YES 2 NO BY 2 Accident 28s. PLACE OF INJURY — At home, farm, street, fectory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, 3 Suicide 6 Could not be ED Ē 29a. CERTIFIER
(Check only one)

29a. MEDICAL EXAMINED. On the best of my knowledge, deeth occurred at the time, data and piece, and due to the ceuse(s) and manner as stated. COMPL 2 MEDICAL EXAMINER: On the beele of examination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(e) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER "CFAIR, P.A. 29c. LICENSE NUMBER BE

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Gracito Patricia 8903 Harford Rd. 32. BEGIS HAR'S SNATURE

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ITEM: 7. PER F.H. FILM G-732 2/6/96 t.t

	1. DECEDENT'S NAME (First, Middle, Las	t)							OF DEATN			3. TIME OF DEAT
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	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. II		IF UNDER 1 YEAR		R 24 HRS.	7. DATE	OF BIRTN			PLACE (State or Fo
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œ	90. FACILITY NAME (If not institution, give MALCOLM GROW ME		TER		CAMP S				S AFB		CE G	EORGE'S
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ы Ш	WILLIAM B YANCE	EY					IZABE			Surrieme)		
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		Robert C	arl And	derson			MONTH	000-64	YEAR 195	08:10AH
		4. SOCIAL SECURITY NUMBER		GE (In yrs. lest birthday,	IF UNDER 1 Y	EAR IF UNDER 24 HRS.	7. DATE OF BIRTH			ACE (Stete or Foreign
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phodes	~	9e. FACILITY NAME (If not institution, give a	treet end number)		9b. CITY, TO	WN OR LOCATION OF D	EATH	9c. COUNT	TY OF DEAT	н
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permit.	RAL	10e. STREET AND NUMBER				101. ZIP CODE		10g. CITIZE	EN OF WHAT	T COUNTRY?
	E	1426	Decatur	St.		21230)	Ini+	2 50	tates
020 physician. burial-transit	FUNE	11. MARITAL STATUS	12. WAS DECEDENT EVE		12 MMC	DECENDENT OF HISPA				
020 physician burlal-tra		1 Never Married 2 Married	FORCES? 1 X YE	ES 2 NO	If ye	e, specify Cuban, Mexic	an, Puerto Rican, etc.)	THE OF INO-	Black, W	American indian, hite, etc.
DO- The The	B	3 XWidowed 4 Divorced	W.W.2	R DATES	10	YES 2 NO Speci	ly:		Specify	hite
2 5 8 5 5	ED	15. DECEDENT'S EDU			<u> </u>					
or all		(Specify only highest grade	completed)	16a, DECEDENT	work done during	PATION g most of working	16b, KIND OF	BUSINESS/INDU	STRY	
0 m	2	Elementary/Secondary (0-12)	College (1-4 or 5+)	IIIe. Do NOT	use retired.)					
AND 2 he hospital detached fo	₹	12th.Grade	none	Poli	ce Off	icer	Balt	o.Cit	V	
the hos detach	COMPLET	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	AME (First, Middle, Maid	ien Sumame)	_	
व देव	ш	Robert C.Ande	rson			Beati	cice	Unkno	own	
retained 5 should	00	19a. INFORMANT'S NAME (Type/Print)		19b, MAILIN	G ADDRESS (St	reet and Number or Rural	Route Number, City or	Town State Zin (Codel	
2 50 5	2	Ms.Roberta C.	Anderson			Mar Rd.				3 21061
Page Page	-	20e. METHOD OF DISPOSITION								
Page 6 may al director, pa		KingBurlel 2 - Cremellon 3 - Rem	oval Irom State	20b. PLACE AND DATE cemetery, crematory or	other place)		1	LOCATION — CI	ity or Town,	State
Page 6 Il direct		4 Donallon 5 Other (Specify)		Maryland	d Vet	Cemt, 118	3/195 Cr	ownsv:	ille	, md.
ALTIN death. Pag tuneral di 	Н	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE		22. NAN	E AND ADDRESS OF FA	CILITY Do 1	to.Md	212	20
ALTI death. P. funeral		► (b (V)								_
PA - 2 (0)	\vdash	Chan hoym	redre		Mc	Cully Fu	neral H	ome,1:	30 E	Fort Ave
cours after the drin by the or removemedical		23. PART i. Enter the diseases, or shock, or heart failure.	complications that cause or List only one cause or	sed the death. Do	not enter the	mode of dying, suc	ch as cardiac or re-	apiratory arres	mt,	Approximata
filled in the or rer	1 1	IMMEDIATE CAUSE (Final	,						İ	Intarval Between Onset and Death
ation the		disesse or condition	Sport	Hic Sh	act				į	6
with plets crem		reaulting in death)		S A CONSEQUENCE						Q
com com	- 1	_	12n0	umonto					i	10
executed and con o burial, matic e	CERTIFICATION	Sequentially list conditions,		S A CONSEQUENCE						10
ior be C	A	if any, leading to immediate cause. Enter UNDERLYING	('+	D1	1				i	a
er t	유	CAUSE (Disease or Injury	c. DUE TO (OR A)	S A CONSEQUENCE O	ing					
S Sell St	Ē	that initiated events resulting in death) LAST				*			i	1.
o Hend	1 1 1		d///	romboc	4 to se	140				7
the dead the dead of Mental		PART II. Other significant condition			1		Book I Or was	A & L & A & TOTAL DE DE LA VILLE DE LA VIL		
Y H S S >	EDICAL			, out not resulting	m the under	lynig cause given in	PERF	AN AUTOPSY FORMED?	AVA	RE AUTOPSY FINDINGS JILABLE PRIOR TO
S E E C	ă						i) (YES	2 🗌 NO		MPLETION OF CAUSE DEATH?
MEC requires seen sign of Heal	ME									YES 2 NO
		DID TOBACCO USE CONTI	RIBUTE TO CAUSE	OF DEATH Y	ES M NO	☐ UNCERTAI	NΠ			
4 9 E E	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DE						
	잃	EXAMINER?	HOSPITAL:		OTHER:	-				
CLA CLA	≝	27. MANNER OF DEATH	1 Inpetient 2 ER/O			Home 5 - Residence				
The state of	효	1 Netural 5 Pending	28e. DATE OF INJUR (Month, Day, Year		JURY	. INJURY AT WORK?	28d. DESCRIBE HO	W INJURY OCCU	RED	
DING PHYS After this death with	B	2 Accident Investigation			M 1	YES 2 NO				
S S S S S S S S S S S S S S S S S S S		3 Suicide 6 Could not be	28e. PLACE OF INJU building, atc. (S	JRY — At home, farm,	street, factory,	office	281. LOCATION (Stre City or Town, Str	et and Number or	r Rural Route	Number,
DR ATTENDING PHYSICIAN: DIRECTOR: After this certifica rours after death with the St.	ETE	4 Homicide determined		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			City or lown, Sia	le)		
DIRECT POURS	3	29e. CERTIFIER	CIANI. To the head of an in-							
	COMPL		CIAN: To the best of my kn							
THE HOSPITAL THE FUNERAL filed within 72 PORTANT: If	8	2 MEDICAL EXAMINE	R: On the besis of examina	mon end/or investigati	on, in my opinio	on, death occured at the	lime, data and place,	end due to the	ceuse(s) and	i manner ea stated.
市 市 市 N	w II	296. SIGNATURE AND TITLE OF CERTIFIER	1/////			29c. LICENSE NU	MBER	29d. DATE	SIGNED (Mod	nth, Day, Year)
TO THE TO THE be fied IMPOR	B	6	1141	- 7	Tulen	AC244	1614-30			bor 5,1995
	2	30. NAME AND ADDRESS OF PERSON WH	OMPLETED CAUSE OF	DEATH (ITEM 27) /TVD	e, Print)	1/1-011		- (TOURNI	201) 1177)
			Tarel	= /	_	11.	6 - 11	. , 1		
		31 DATE FILED (Month Don Aber)	1 magnetones	posits.	en mi	> (400)	100 /10	PITGI		
		NOV 0 8 1995	in the state of the	A.C. A. S.		er.				
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BE COMPLETED

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2 MEDICAL EXAMINER: On the basis of exemination and/or

	FOR STI	TE OF MAD	/I AND / DEDAG	TREFAIT	05.11	CALTIL	AND I	MENTAL HVOICE		5	33329
	1 - STATE REGISTRAR	ALE UP MIAN	CERTIF					MENTAL HYGIEI REG. NO			
	1. DECEDENT'S NAME (First, Middle, Last)							2. DATE OF DEATH			3. TIME OF DEATH
	Gerald N Andre	WS Sr.						November	5	1995	3:40 a M
	4. SOCIAL SECURITY NUMBER 5. SEI	X 8. AG	SE (In yrs. last birthday) 59 YRS.	IF UNDER	1 YEAR DAYS	IF UNDER :	MIN.	7. DATE OF BIRTH (Month, Day, Year) June 13,		_	HPLACE (State or Foreign
	9a. FACILITY NAME (If not institution, give street and	f number)		9b. CITY,	TOWN C	A LOCATIO	N OF DE	A	_	UNTY OF D	
HC C	Bayview			Ва	lti	nore				N/A	
5	RESIDENCE OF DECEDENT 10a, STATE 10b, COUNTY					(Dec)			-		-
DIRECTOR	Md N/A			y, rown o altim		KON					10d. INSIDE CITY LIMITS? 1 A YES 2 NO
Z	10e. STREET AND NUMBER				101	ZIP CODE			10g. Cl		WHAT COUNTRY?
崱	3034 Hudson Street					21	224			US	A
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	AS DECEDENT EVE DRCES? 1 , YI YES, GIVE WAR OF	R IN U.S. ARMED ES 2 NO R DATES	11	f yes, sp		, Mexica	NIC ORIGIN? (Specify You, Puerto Rican, etc.) y:	es or No-	Spec	
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade complet Elementary/Secondary (0-12) Colle	red)	16a. DECEDENT'S (Give kind of life. Do NOT u	work done a	CCUPATIO	DN st of working	7	16b. KIND OF B	USINESS/IN		hite
AP.	12		Fork	Lift	: Op	erato	r	Uni	ivers	al F	oods
ő	17. FATHER'S NAME (First, Middle, Last)					18. MOTH	ER'S NA	ME (First, Middle, Maide	n Surname)		
BE (David Andrews					Grac	е В	oice			
10	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS	(Street a	nd Number	or Rural	Route Number, City or To	wn, State, 2	(ip Code)	
-	Joan Andrews		3034	Huds	on	Stree	t,	Baltimore,	Md.	212	24
	20s. METHOD OF DISPOSITION 1 ∰ Buriel 2 ☐ Cremation 3 ☐ Removal tro	om State	20b. PLACE AND DATE cemetery, crematory or o	ther place!					OCATION -		
	4 Donation 5 Other (Specify)		Garrison	Fores				11/8 Ow:	ings	Mill:	s, Md.
	21. SGNATURE OF FUNERAL SHAVICE LICENSEE	0.0				Asht		ciuiy Funeral Ho	ome		
	Aun o de									alto	, Md. 21224
	23. PART I. Enter the diseases, or compli- shock, or heart failure. List or IMMEDIATE CAUSE (Finel										Approximata interval Between Onset and Deatl
	disease or conditiona.	Myzogaro	dial infar	atio	n						3 days
	resulting in death) a	DUE TO (OR A	dial infar AS A CONSEQUENCE O	F):	11						3 days
z											
ERTIFICATION	Sequentially list conditiona, if any, leading to immediate	DUE TO (OR A	AS A CONSEQUENCE O	NF):							
S	cause. Enter UNDERLYING CAUSE (Disease or injury									_	
브	that initiated events resulting in death) LAST	DUE TO (OR A	AS A CONSEQUENCE O	F):							
HH	d.										
CC	PART ii. Other significent conditions cont	tributing to deet	h but not reaulting	in the un	derlyin	g cause g	Iven in			Y 24	b. WERE AUTOPSY FINDINGS
S	_Myocardial infarct	ion 11/2	2 with pro	bable	e ex	tens	ion	1 YES	PRMED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE
MEDICAL	of infarct as caus							_	" LX"		OF DEATH?
	DID TOBACCO USE CONTRIBUT				NO [UNC	ERTAI	N 🗆			
IA	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEA								
SIC		SPITAL: inpatient 2 - ER/0	Outpatient 3 DOA	OTHER 4 Num		e 5 🗆 Re	sidence	8 Other (Specify)			
Y PHYSICIAN:	1 🔀 Natural 5 🗌 Pending	(Month, Day, Yei		_	28c. IN.			28d. DESCRIBE HOW	O YRULMI	CCURED	
ED BY	The second secon	28s. PLACE OF INJ building, stc. (URY — At home, farm, Specify)	street, fact	tory, offic	•		28t, LOCATION (Stree City or Town, Stell	et and Numb	er or Rural	Route Number,

NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (7/1) Johns Hopkins Bayview Medical Center 4940 Eastern Ave., Baltimore, MD 21224 er 31. NOV 0 8 1995

investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated.

29c. LICENSE NUMBER

29s. CERTIFIER (Check only one)

2 CERTIFYINO PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

29d. DATE SIGNED (Month, Day, Your)

Novembar 6.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed without 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be netified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT	T OF HEALTH AND MENT	AL HYGIENE
CERTIFICATI	E OF DEATH	REG. NO.

1 - STATE REGISTRAR	STATE OF MARYLAND / DEPARTM CERTIFICA	ENT OF HEALTH AND MI	ENTAL HYGIENE REG. NO.	
1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH	3. TIME OF DEATH
Jeannet	te BAiley		NOV, 07	95 12:30 PM
11111111	5. SEX 1 M 2 F 6. AGE (In yrs/lest birthdey) IF to Mon		7. DATE OF BIRTH (Month, Day, Year) 01-15-23	8. BIRTHPLACE (Stere or Foreign
Se FACILITY NAME (If not institution, give stre	eet and number) 9b.	CITY, TOWN OR LOCATION OF DEAT	H Sec. CON	INTY OF DEATH
RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY	LIOSPICI I	WHO OR LIDCATION	14	10d. INSIDE CITY
Md	V/A B	altimore		LIMITS?
3219 CACAMO	int aug	101. ZIP CODE	3 10g. Cr	TIZEN OF WHAT COUNTRY?
11. MARITAL STATUS 1 Nover Married 2 Married	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 PNO	13. WAS DECENDENT OF HISPANIC If yes, specify Cuban, Mexican,		14. RACE — American Indian, Black, White, stc.
3 Widowed 4 Divorced	IF YES, GIVE WAR OR DATES	1 TES 2 7 NO Specify:	4	Back
15. DECEDENT'S EDUCA (Specify only highest grade of Elementary/Secondary (0-12)		done during most of working	16b. KIND OF BUSINESS/II	NOUSTRY
17. SATHER'S NAME (First, Middle, Last)	6 Cer	18 MATHER'S NAME	E (First, Middle Melden Sugnarge)	ent slore
Louis E. Lo	swman Sr	Viole	Ta Dodd	,
19a. INFORMANT'S NAME (Type/Print)	19b, MAJLING ADD	ORESS (Street and Number or Rural Roll	ute Number, City or Town, State	3altingremd
20a. METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 Remov	20b. PLACE AND DATE OF DI		DATE 20c. LOCATION -	- City or Town, Stata
4 Donation 6 Other (Specify) 21. SIGN TURN OF FUNERAL SERVICE LICE	val from State Children, crematory or other company.	22. NAME AND ADDRESS OF FACH	13/9 0001	ngs Mills Ma
* Jeseph	L. Kuss	2222 W. A	orth au	21216
23. PARTIE. Enter the disease, or co shock, or heart failure. L.	omplications that caused the death. Do not e ist only one cause on each line.	enter the mode of dying, such	as cardiac or respiratory a	Interval Between
IMMEDIATE CAUSE (Final disease or condition resulting in death)	Reval failur Due to (or as a consequence of):	re		Onset and Death
Sequentially list conditions, b.				
If any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A CONSEQUENCE OF):			
CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEQUENCE OF):			
PART II. Other significant conditions	contributing to death but not resulting in the	ne undarlying cause given in P	art I. 24a. WAS AN AUTOPS'	Y 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO
congestive hear	at fatilize		1 YES 2 NO	COMPLETION OF CAUSE OF DEATH?
	IBUTE TO CAUSE OF DEATH YES	□ NO Ø UNCERTAIN	-	1 TES 2 NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER?		HER:	-23 - 2	
27. MANNER OF DEATH	28a. DATE OF INJURY 26b. TIME OF	Nursing Home 5 Residence 6	Other (Specify) 28d. DESCRIBE HOW INJURY O	CCURED
1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year) INJURY	M 1 YES 2 NO		
3 Suicide 6 Could not be 4 Homicide determined	26e. PLACE OF INJURY — At home, term, stree building, etc. (Specify)	t, tectory, office	26f. LOCATION (Street and Numb City or Town, State)	er or Rural Route Number,
000)	CIAN: To the best of my knowledge, death occurred at 8: On the basis of examination end/or investigation, in			
29b. SIGNATURE AND TITLE OF CERTIFIER	1eyMD	29c. LICENSE NUMB	29d. D.	ATE SIGNED (Month, Day, Year) AND MARKET 7 1995
	COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Prin	10)	,	0 - 22
I (1HV) (TIMPINED Y	VENENICU -	1. Al 11 1	1. (A .DA -	
CITKISTOPITEC J 31. DATE FILED (MORTH, Day, Mort) MOV 0 81995 L	LEARNEY 700 L	VASHINGTON B	SIVD BALT	November 7 1995 MD 21230

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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the host and reduced by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Merital Hygiene prior to burial, cremation, or removal.

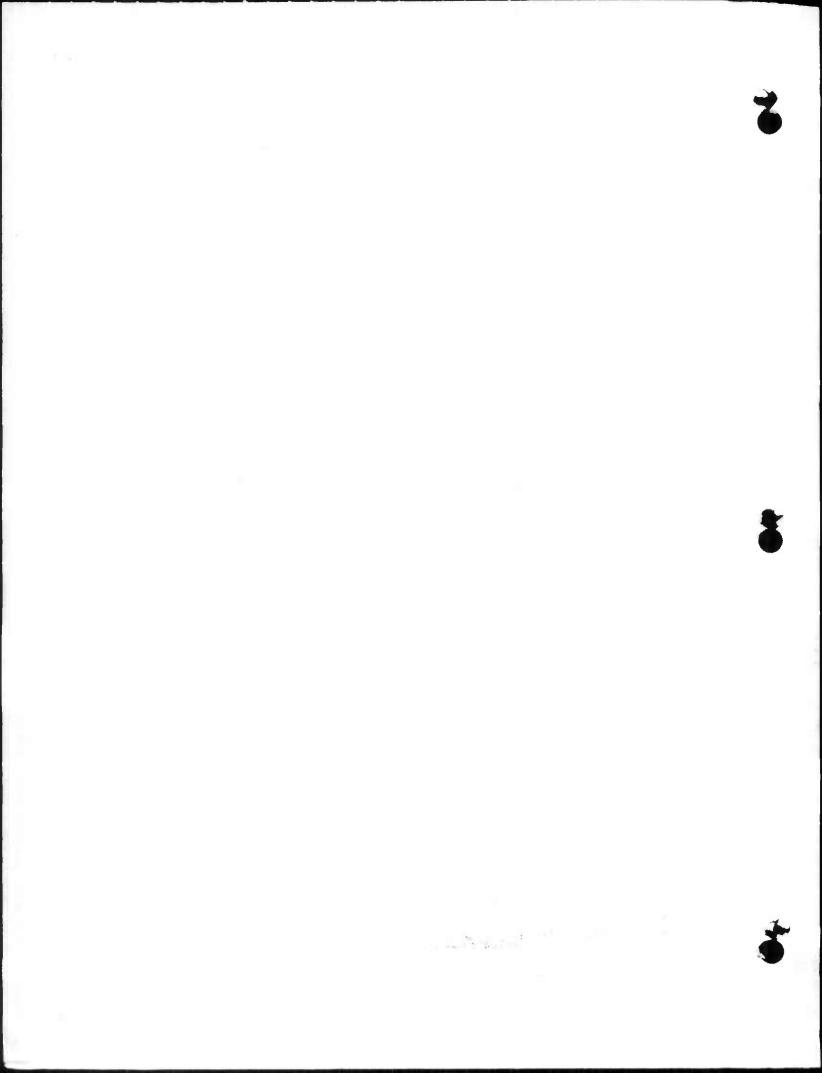
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

	REGISTRAR		CEH	HIFICA	ALE OF	DEATH	F	REG. NO.		
1	1. DECEDENT'S NAME (First, Middle, Last) Richard A. Brisc	00.		-			2. DATE OF MONTH	DAY	YEAR	3. TIME OF DEATN
COMPLETED BY FUNERAL DIRECTOR	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last bin	et et al. mi	INDER 1 YEAR		Octobe		95	13:30 p M
	216-36-1470	1 🔀 M 2 🗆 F	rr		THE DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF	PY Your 940	Coun	HPLACE (State or Foreign
	Sa. FACILITY NAME (If not institution, give a	treet and number)		9b.	9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH					
OR	467 Walton Court	B	Baltimore							
2	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT									
DIRE	Maryland		wn or loca timore					10d. INSIDE CITY LIMITS? Y YES 2 NO		
	10e. STREET AND NUMBER					r. ZIP CODE		10a C	ITIZEN OF	WHAT COUNTRY?
VER/	467 Walton Court				21201					
5	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. VARMED FORCES? 1 VES 2 2 No.				13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— 14. If yes, specify Cuben, Maxican, Puerto Rican, etc.)					E — American Indian, k, White, atc.
	1 🔀 Never Married 2 🗍 Married 3 🗍 Widowed 4 🗍 Divorced	IF YES, GIVE W				3 2 X NO Speci		n, oraș	Spec	Black
	15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	16a. DECED	ENT'S USU	AL OCCUPATI	ON pet of warting	16b. KII	ND OF BUSINESS/I	NDUSTRY	
	Elementary/Secondary (0-12)	College (1-4 or 5 +) life. Do	NOT use reti	red.)	ost or working	CON	STRUCT	TAN	
	10TH 17. FATHER'S NAME (First, Middle, Last)		LAE	OK						
	Robert A. Bris	coe				Sadie		le, Maiden Sumame)	
BE	19a. INFORMANT'S NAME (Type/Print)		19b. M	AILING ADD	RESS (Street	and Number or Rural			Zin Code)	
٩	ROBERT A. BILL					ood ave		ony or norm, plane, i	L.p. 0000)	
	20e METHOD OF DISPOSITION 1 Deurlal 2 Cremation 3 Rem 4 Donation 5 Other (Specify)	avel from State	20b. PLACE AND	DATEOFDI	SPOSITION (N	ame of	DATE	20c. LOCATION	- City or To	own, State
	4 Donation 5 Other (Specify)	n State	GREEN	MÖÜ	T CE	METERY	10-3	0-95 B	ALTO	MD.
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE Ronald	wade, D	m.	State		Board			imore Stree
_	23. PART I. Enter the diseases, or o				Rm.BC	126-Balt	more,	Maryland	1 21	201-1559
	shock, or heart fellure. IMMEDIATE CAUSE (Finel disease or condition resulting in death)	List only one ceu	Se on each line. Preuss	ton		or dying, suc	on as carding	or reapreatory a	irrea(Approximate Interval Between Onset and Death
		DUE TO	OR AS A CONSEQUE	YCE OF):		4	(C.26)	000		- Comme
NO N	Sequentially list conditions, The Chrose Pelancy Asease - Englacer Sylvan Sylvan								Syears	
CERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING		OH AS A CONSEQUE	ice or;						
띮	CAUSE (Disease or Injury that Initiated events	DUE TO	OR AS A CONSEQUEN	HCE OF:						-
ᇤ	resulting in death) LAST									
	PART II. Other significent condition	a contributing to	death but not resul	Iting in th	e underlyln	a cause alven in	Bart I I as	n. WAS AN AUTOPS	. 1	. WERE AUTOPSY FINGINGS
EDICAL	HIV disease				o underlyin	y cause given in		PERFORMEO?	248	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
Σ			V					, ,		1 YES 2 NO
Ž	DID TOBACCO USE CONTI	RIBUTE TO CAI				UNCERTAI	N 🗆			
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	28. PLACE OF	OT	HER:	- /				
¥ ¥	YES 2 □ NO 27. MANNER OF DEATH	1 L Inpatient 2 L	ER/Outpetlant 3 🗆 (1	ne 5 Rasidence				
	Netural 5 Pending	(Month, Da		b. TIME OF INJURY	WC	URY AT ORK? YES 2 NO	28d. DESCRI	BE HOW INJURY O	CCURED	
B	2 Accident Investigation 3 Suicide 8 Could not be	28e. PLACE OF	INJURY — Al home,	larm, atreet			28L LOCATIO	N (Street and Numb	er or Rumi i	Doude Number
COMPLETED	3 Suicide 8 Could not be 4 Homicide detarmined	building, a	itc. (Specify)		, , , , , , , , , , , , , , , , , , , ,	-	City or To	wn, State)	er or norar	route Namber,
밁	29a, CERTIFIER (Check only	CIAN: To the best of	my knowledge, death o	occurred at	the time date	and place, and due	to the causele) and magner as a	lete d	
<u> </u>	one) 2 MEDICAL EXAMINE	R: On the baels of ex	amination and/or inves	rtigation, in	my opinion, d	leath occured at the	time, data and	place, and dua to	the cause(i	a) and manner se stated.
ŭ	296. SIGNATURE AND TITLE OF RENTIFIER					29c. LICENSE NU				(Month, Day, Year)
<u>ا</u> ۱	Mondey States	the ma				D130		>	10/19	1911
일	30. NAME AND ADDRESS OF PERSON WHO	O OMPLETED CAUS	E OF DEATH (ITEM 27)	(Type, Print,					0/17	114
	PONALD S	POTOT	SKY M	· D.	821	N. Eur	ow ST	Buro)	40	2120]
	NOV 0 8 1995 d	32. HEGISTRAI	R'S SIGNATURE							





1995

9c. COUNTY OF DEATH

Baltimore

10g. CITIZEN OF WHAT COUNTRY?

USA

3. TIME OF DEATH

1:30

10d. INSIDE CITY

1 TES 2 NO

8. BIRTHPLACE (State or Foreign

2. DATE OF DEATH

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FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

CELIA

within 24 hours after death. OR ATTENDING PHYSICIAN: The DIRECTOR: / TO THE HOSPITAL

TO THE FUNERAL (
be filed within 72 h

IMPORTANT: If it HOSPITAL

4 Homicide

(Check only one)

BE

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295. SIGNATURE AND TITLE OF CERTIFIES

31. DATE FILED (Month, Day, Yeer) NOV 0 8 1995

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determined

4. SOCIAL SECURITY NUMBER 8. BEX 8. AGE (In yrs. lest birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH (Month, Day, Year, IF UNDER 24 HRS. 1 M 2 F 060-05-4137 83 Jan 1 9s. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH St. Joseph Nursing Home DIRECTOR Pages 1, 2, 3 Catonsville RESIDENCE OF DECEDENT 10b. COUNTY 10c, CITY, TOWN OR LOCATION Frederick Frederick permit, FUNERAL 10a. STREET AND NUMBER 101. ZIP CODE 2933 Rhoderick Road use as the burial-transit 21704 the hospital or attending physician, 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ∑NO IF YES, OIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-if yes, specify Cuben, Mexicen, Puerto Rican, etc.) AND 21215-0020 1 Never Merried 2 Merried 1 TYES 2 TO NO Specify: BY 3 😡 Widowed 4 🗌 Divorced COMPLETED 19s. DECEDENT'S USUAL OCCUPATION (9Ne kind of work done during most of working life. Do NOT use retired.) 18. DECEDENT'S EDUCATION (Specify only high signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for Heath and Mental Hygiene prior to burial, cremation, or removal. interv/Secondary (0-12) Homemaker once. 17. FATHER'S NAME (First, Middle, Last) Joseph Zdanowicz 76 retained by BE notified 19e. INFORMANT'B NAME (Type/Print) 19b, MAILINO ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 Romulada C. Biosca must be 20a. METHOD OF DISPOSITION

1 🔀 Burlet 2 🗆 Cremetion 3 🗆 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE cometery, crematory or other place)
Gate of Heaven 4 ☐ Donation S ☐ Other (Specify) examiner 21. SIGNATURE OF FUNERAL SERVICE DICENSEE Mosso 11 medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such se cerdisc or respiratory errest, shock, or heart failure. List pnly one cause on each line Want TO (OR AS A CONSEQUENCE OF) IMMEDIATE CAUSE (Finei the disease or condition resulting in death) event, traumatic CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF): if eny, leeding to immediate ceuse. Enter UNDERLYING CAUSE (Diseese or injury or other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in deeth) LAST DIVISION OF VITAL RECORDS PART II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL Mare PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES □ NO □ UNCERTAIN □ has b Dept. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER:
4. Nursing Home 5 Residence 8 Other (Specify) 1 YES 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 0 the 27. MANNER OF DEATH 28s. DATE OF INJURY (Month, Day, Year) After this ce feath with ti marked, 28c. INJURY AT 1 Natural 8 Pending ВУ 1 YES 2 NO After death 2 Accident Investigation 28e. PLACE OF INJURY — At home, farm, strest, factory, office building, etc. (Specify) 28 is I 3 Suicide COMPLETED 6 Could not be

OF CAUSE OF DEATH (ITEM 27) (Type, Print)

Ρ.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE **CERTIFICATE OF DEATH**

BIOSCA

 RACE — American Indien, Black, White, stc. Specify: white 18b. KIND OF BUSINESS/INDUSTRY Own Home 18. MOTHER'S NAME (First, Middle, Malden Sumame) Filimena Budrewicz 2933 Rhoderick Road, Frederick, Md. 21704 20c. LOCATION — City or Town, State Silver Spring, Md 22. NAME AND ADDRESS OF FACILITY
Sterling Ashton Funeral Home 736 Edmondson Avenue, Balto, Md. Interval Between Onset end Death 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE 24s. WAS AN AUTOPSY 1 - YES 2 NO OF DEATH? 1 TES 2 NO 28d. DESCRIBE HOW INJURY OCCURED 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 1 CERTIFYINO PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(e) and menner se stated. 2 MEDICAL EXAMINER: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner es stated. 29c. LICENSE NUMBER 29d. DATE SIQNED (Month, Day, Year) 405 DHMH-18 Rev 1/89

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within to The Found of the retained by the hospital or attending physician.

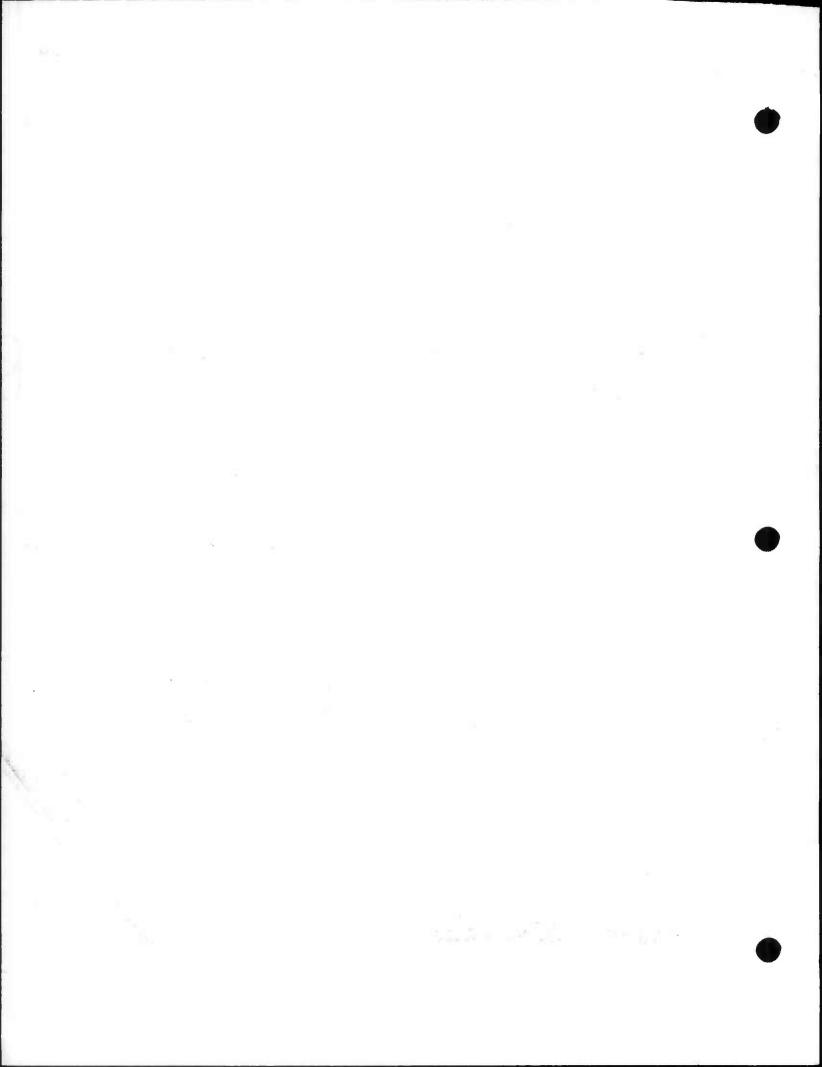
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlat-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlat, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

	1 - STATE REGISTRAR	STATE OF MARYL			HEALTH AND	MENTAL	HYGIEN	E			
	1. DECEDENT'S NAME (First, Middle, L ALBERT	ast)		BUR	NS	MONTH	OF DEATH	1995		TIME OF OEATH 2:02A	м
	4. SOCIAL SECURITY NUMBER 220 20 2293 9a. FACILITY NAME (If not institution, g	1 € M 2 □ F	(In yrs. lest birthdey) 66 YRS.	IF UNDER 1 YEA MONTHS DAY 9b. CITY, TOW		7. DATE (Month)	OF BIRTH Day, Year)	8.8	ountry) orth	ACE (State or Foreign	
DIRECTOR	RESIDENCE OF DECEDEN	OPKINS HOSPITA	AL	BA	LTIMORE C	ITY			NA		_
	Maryland 106. co	NA	10c. CIT	Y, TOWN OR LO	cation Baltimo:	re C.	ity			d. INSIDE CITY LIMITS? X YES 2 NO	
FUNERAL	2920 East Fe				101. ZIP CODE 212	213		10g. CITIZEN	JSA	T COUNTRY?	
ΒX	11. MARITAL STATUS 1 Never Married 2 X Married 3 Divorced	12. WAS DECEOENT EVER I FORCES? 1 12 YES IF YES, GIVE WAR OR D	2 NO	If yes,	PECENDENT OF HISPA specify Cuban, Maxic ES 2 NO Speci	en, Puerto R			RACE — Black, W Specify:	American Indian, Thita, etc. Black	
COMPLETED	15. DECEDENT'S (Specify only highest (Elementary/Secondary (0-12)	EDUCATION grade completed) College (1-4 or 5+)	18a. DECEDENT'S (Give kind of ville. Do NOT us	work done during se retired.)	most of working	16b.		INESS/INDUST			\exists
	11 17. FATHER'S NAME (First, Middle, Last	,	Plumber	/Pipef:	18. MOTHER'S NA	112	liddle, Maiden	ool Sy Surname)	ste	em	
TO BE	Albert Smith 19a. INFORMANT'S NAME (Type/Print)				Glady:	Route Numb	er, City or Town				-
	Matilda Burn 20a. METHOD OF DISPOSITION 15 Duriel 2 Cremetton 3 1 4 Donatton 8 Other (Specify)	Removal from State	b. PLACE AND DATE	OF DISPOSITION		OATE	20c. LO	CATION — City of	r Town,	State	3
	4 Donation 8 Other (Specify)		arrison	Forest 22. NAME Tri	Cem. 11 AND ADDRESS OF FA State 1 3rd St.,	kuny Fune:	cal S	ervice	es,	Inc.	
CERTIFICATION	23. PART I. Ener the diseases, shock, pr heert falls immediate CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	a. Aububab oue to (or as a current of the current	each line.	Sive	mode of dying, suc	ch aa card	lac or reaple	ratory arrest,		Approximate Interval Betwood Onset and Design Control of the cont	eeth
ÄL	PART II. Other significent cond	itiona contributing to death t	but not resulting	In the underly	ing ceuse given in	Part I.	24a. WAS AN PERFORM	MED?	CO OF	RE AUTOPSY FINDINGLABLE PRIOR TO MPLETION DF CAUS DEATH? YES 2 14 NO	
PHYSICIAN: MEDIC	DID TOBACCO USE CO 25. WAS CASE REFERRED TO MEDICA EXAMINER?		OF DEATH YE			N 🗆				J TES Z ENO	
PHYS	1 YES 2 NO 27. MANNED OF DEATH	1 Inpatient 2 ER/Out	28b. TIM	4 Nursing H	ome 5 Residence NJURY AT WORK?			JURY OCCURE)		\dashv
B	1 Natural 5 Pending 2 Accident Investigati 3 Suicide 6 Could not determine	be 28e. PLACE OF INJURY building, etc. (Special	Y — At home, ferm, s	M 1	YES 2 NO	281. LOCA	TION (Street a	nd Number or Ru	ral Route	Number,	\dashv
COMPLETED		HYSICIAN: To the beat of my know MINER: On the basis of examination							se(e) an	d menner as state	d.
TO BE C	30. NAME AND ADDRESS OF PERSON	whi	MD	Print)	MG (195		29d. DATE SIG	mb	9219	7
	Greg ory)	Transman sign	Tower	110	Johns Ha	ophi	25 Ho	spilal	Ball	hmore Md	1
	NOV 0 81995	the Commented	J							DHMH-18 Re	1/80



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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlal-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlal, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF	MARYLAND /	DEPARTMENT	OF HEALTH	AND	MENTAL	HYGIENE
	CI	ERTIFICATE	OF DEAT	ГН		REG. NO.

	1 - FOR STATE REGISTRAR	STATE OF MARYLA		RTMENT OF H		MENT	AL HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Last)	Mary R. H				MON	E OF DEATH	MY	YEAR	3. TIME OF DEATH
	040 04 0404	i. SEX 8. AGE (Ir	yrs. last birthday) 35 vns.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	(Mo	E OF BIRTH nth, Day, Year)	1995 1910	Counti	10:50 AM M IPLACE (State or Foreign y) yland
TOR	96. FACILITY NAME (If not institution, give atree Perring Parkway Me: RESIDENCE OF DECEDENT		ome	9ь. сіту, тоwn с Parky	r LOCATION OF DI			9c. COU	nty of D ltim	EATH
DIRECTOR	Maryland Bal	timore	18c. CI	ry, town on locat Parky						10d. INSIDE CITY LIMITS? 1 TYES 2 THO
FUNERAL	1801 Wentworth- Pe	rring Pkwy N	Meridian		. ZIP CODE	234			USA	VHAT COUNTRY?
Β¥	11. MARITAL STATUS 1 Never Merried 2 Married 3 Widowed 4 Divorced	2. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DAT		If yes, sp	ENDENT OF HISPAR ecity Cuben, Mexica 2 NO Specif	n, Puert	IIN? (Specify Ye o Rican, atc.)	or No—		E — American Indian, k, White, etc. //y: white
COMPLETED	15. DECEDENT'S EDUCAT (Specify only highest grade cor Elementary/Secondary (0-12)	mpleted)		USUAL OCCUPATION Work done during mose retired.)		16	5b. KIND OF BU	SINESS/IND	PUSTRY	WILCE
MPL	8th	College (1-4 or 5+)	Homen	aker				n Own	Hom	e
BE CC	William Scharre:	r			18. MOTHER'S NA		Myers	Sumame)		
10	190. INFORMANT'S NAME (Type/Print) Margaret Delorenzo			Aconess (Street a Hartwait						
	20e. METHOD OF DISPOSITION 15/2 Burlel 2 Cremetion 3 Remove 4 Donation 5 Other (Specify)	I from Stata come	PLACE AND DATE	OF DISPOSITION (Na	me of	-	TE 20c, LC	CATION —	City or To	wn, State Maryland
	21. SIGNATURE OF FUNERAL SERVICE LIGEN	see Carpe	ntei	Burgee	D ADDRESS OF FA	une	ral Ho	ne		and 21211
	23. PART I. Enter the Sidesees, or conscious abock, or heart fellure. Lie IMMEDIATE CAUSE (Final disease or condition resulting in death)	Public U	le 5	not enter the mo	de of dying, suc	h aa ca	rdiac or reap	iretory arr	eat,	Approximata Interval Between Onset and Death
CERTIFICATION	Sequantially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A C	CONSEQUENCE	de di	e g					
MEDICAL (PART II. Other algorificant conditions of Device Line Conditions of the Conditions o	contributing to death bu	t not reaulting	in the underlying	ceuse given in	Part i.	24a. WAS AN PERFOI 1 TYES 2	RMED?	24b.	WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 2 YING
	DID TOBACCO USE CONTRIB			S NO TH (Check only one)	UNCERTAIN	V 🗆				,
PHYSICIAN:	EXAMINER?	OSPITAL:		QTHER:	6 🗆 Residence	6 🗆 Ott	ner (Specify)		_	
ВУ РН	27. MANNER OF DEATH 1 Natural 6 Pending 2 Accident Investigation	26a. DATE OF INJURY (Month, Day, Year)	28b. TIM	URY WO	JRY AT RK? ES 2 NO	28d, DI	SCRIBE HOW	NJURY OCC	URED	
	2 Accident Investigation 3 Suicide 5 Could not be detarmined 4 Homicide detarmined 25a. PLACE OF INJURY — At home, farm, street, fectory, office building, stc. (Specify) 25a. LOCATION (Street and Number or Rural Route Number, City or Town, State)						loute Number,			
COMPLETED	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAL (Check only one) 2 MEDICAL EXAMINER: C	N: To the best of my knowle	dge, death occurr	ed at the time, data on, in my opinion, de	and plece, and due	to the ci	suse(s) and me	nner as state	ed.) and menner as stated.
TO BE C	29b, SIGNATURE AND TITLE OF CERTIFIER	Toupe	noue	ui	29c. LICENSE NUM D 30		61	29d. DATE	SIGNED	Marin, Day, war the which 7 1995
	30, NAME AND ADDRESS OF PERSON, WHO C	OMPLETED CAUSE OF BEAT		allio	70 T	180	Ala	me 217	29	7
-	31-NOVO 81995	3 REGISTRAR GRA	TUDE							

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND	/ DEPARTMENT	OF HEALTH AND	MENTAL HYGIENE
	CERTIFICATE	OF DEATH	REG. NO.

	1 - STATE REGISTRAR	STATE OF MARYLANI	D / DEPART	MENT OF H	IEALTH AND	MENTAI	HYGIEN	E		
	1. DECEDENT'S NAME (First, Middle, Last) JAMES CHAR	LES BLEDS	SOE			2. DATE MONTH	OF DEATH	3 190	YEAR 3	TIME OF DEATH
	4. SOCIAL SECURITY NUMBER 214-56-5611	1 XM 2 □ F 45	6. AGE (In yrs. last birthday) F UNDER 1 YEAR F UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) Sept 24, 1950 Maj							ACE (State or Foreign
TOR	9a. FACILITY NAME (If not institution, give str Mercy Hospital RESIDENCE OF DECEDENT	set and number)		saltimor	OR LOCATION OF D	EATH			ry of dea Limor	e City
DIRECTOR		imore City		timore	TION				1	Od. INSIDE CITY
FUNERAL	3423 Hickory Aver	nue		101	21211				EN OF WH	AT COUNTRY?
ВУ	1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U.S FORCES? 1 X YES 2 IF YES, GIVE WAR OR DATES	□ NO	13. WAS DEC If yes, sp 1 YES	ENDENT OF HISPA ecity Cuban, Mexico 2 (1) NO Special	NIC ORIGIN an, Puerto F ly:	? (Specify Yes tican, etc.)	or No — 1	Black, 1	American Indian, White, etc. White
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12)	ATION 18a College (1-4 or 5+)	DECEDENT'S US (Give kind of wor life. Do NOT use i Plumbe	rk done during mo retired.)		16b.	KIND OF BUS			
DMG	17. FATHER'S NAME (First, Middle, Last)		FIUID	ST	18. MOTHER'S N/	Dec 27- 1	Contr		19	
	James Bledsoe				Franc		Nea			
) BE	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING A	DDRESS (Street a	nd Number or Rural				Code)	
5	Kimberly Bosley				ut Avenu					and21211
	20a, METHOD OF DISPOSITION 1 X Buriel 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of cametery, crematory or other place) Sacred Heart of Jesus 11/6 Baltimore. Maryland									
	21. SIGNATURE OF FUNCTION BEHAVICE LICE	B. Hen		3631	o address of fa e-Henss Falls Ro	ad, I	Baltim	ore,	2121 Mary	
	23. PART I. Enter the diseases, or co shock, or heart failure. L	omplications that caused the list only one ceuse on each	death. Do not	enter tha mo	de of dying, auc	ch se card	iac or respi	ratory arre	st,	Approximate interval Between
	iMMEDIATE CAUSE (Finel disease or condition resulting in death)	HEM	770	Circ	1105515					Onset and Death
	DUE TO (OR AS A CONSEQUENCE OF):									
ATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING b. ALCOHOL ABUSE DUE TO (OR AS A CONSEQUENCE OF):									
CERTIFICATION	CAUSE (Disease or Injury that initiated events resulting in death) LAST d									
AL	PART II. Other algnificant conditions	contributing to death but no	ot resulting in	the underlying	cause given in	Part i.	PERFORMED? AN			ERE AUTOPSY FINDINGS MILABLE PRIOR TO DMPLETION OF CAUSE
PHYSICIAN: MEDIC	DID TOBACCO USE CONTR	IBUTE TO CAUSE OF D	EATH YES	Пиок	UNCERTAI	N [<u>G</u> io		F DEATH?
CIAI	25. WAS CASE REFERRED TO MEDICAL	26. P	LACE OF DEATH	(Check only one)						
YSI	1 YES 2 NO	HOSPITAL: 1 Inpatient 2 ER/Outpatient	3 DOA 4	THER:	5 Residence	6 K Other	(Specify) H	OSPICI	E	AT MERCY
ву Рн	27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	26a. DATE OF INJURY (Month, Day, Year)	26b. TIME C	Y WO	URY AT RK? 'ES 2 NO	28d. DES	CRIBE HOW IN	JURY OCCU	RED	
	3 Suicide 6 Could not be 4 Homicide detarmined	26e. PLACE OF INJURY — A building, atc. (Specify)	t home, farm, stra	et, factory, office			TION (Street a r Yown, State)	nd Number or	r Runal Rou	le Number,
COMPLET	29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER	IAN: To the best of my knowledge : On the besis of examination and	, death occurred a	at the time, date in my opinion, de	end place, and dua eath occured at the	to the caus	se(s) and man	ner an stated	l. cause(a) a	nd manner as stated.
B	29b. SIGNATURE AND TITLE OF CERTIFIER	Demoun			29c. LICENSE NUI		,	29d. DATE 5	SIGNED (M	onth, Day, Year)
2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEATH (im) 5810 BIT	DYO BELAN	in i	212	06		
	31. NUV 8 1995 Jul	32 REGISTRAR'S SIGNATUR	E							

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TENDING PRYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	R. After this	er death v	28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HOSPITAL OR ATTENDING PHYSICIAN:	R. After the	be filed within 72 hours after death with the Sta	IMPORTANT: If item 28 is marked, or ite

	FOR 1 - STATE REGISTRAR	STATE OF MARY				MENTA				
	1. DECEDENT'S NAME (First, Middle, Last) HELEN	CHAPPLE				MONT	OF DEATH		EAR	TIME OF DEATH 1;00 A M
	4. SOCIAL SECURITY NUMBER 215–28–1044	5. SEX 6. AGE	(In yrs. last birthda) 50 yes.	MONTHS D				- 1	Country)	CE (State or Foreign
OR	96. FACILITY NAME (If not institution, give s Stellar Maris	treet and number)				EATH				н
DIRECTOR	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNT						d. INSIDE CITY			
AL DI	Maryland 100. STREET AND NUMBER	N/A	В	Baltimon	101. ZIP CODE		REG. NO. 2. DATE OF DEATH MONTH DAY MOVEMBER 6, 1995 7. DATE OF BIRTH JUN. 21, 1945 109. CITIZEN OF WHI JU.S.A. CORIGIN? (Specify Yee or No— Puerto Rican, etc.) 16b. KIND OF BUSINESS/INDUSTRY HOSpital E (First, Middle, Maiden Sumame) BOYD ON SIL THOME East AVENUE/Baltimore, N as cardiac or respiratory arrest, GEAL INFECTION ON SIL ATT I. 24a. WAS AN AUTOPSY PERFORMED? 1 PES 2 NO 1	YES 2 NO		
FUNERAL	2415 Annapolis Ro				21230					
B	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Divorced	IN U.S. ARMED 3 2 NO DATES	If yo	s, specify Cuben, Mexic	an, Puerto	N? (Specify Yee of Rican, etc.)	or No — 14	Black, W	American Indien, hite, atc. Black	
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	CATION completed) College (1-4 or 5+)	(Give kind of life, Do NOT	of work done duri use retired.)		168	. KIND OF BUSI	NESS/INDUS	STRY	22401
OMP	12th 17. FATHER'S NAME (First, Middle, Last)			aborer	18. MOTHER'S N					
BE C	Arthur Harris				# UNDER 1 YEAR # UNDER 24 HRS. TO DATE OF BIRTH JOURN'S DAYS HOURS MIN. JUNN'S 1 1989 (1) 100 JUNN'S 1 1989 (
TOB	190. INFORMANT'S NAME (Type/Print) Myron Chapple		19b. MAILI 330	ng address (s E. 28th	treet end Number or Rural	Route Num	ber City or Town.	stute, Zip Ca arylar	nd 21	.218
	1 N Burdel 2 Connection 2 Demonstrate Control									
	23. PART 1. Enter the diseases, or ahock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. ACUTE DUE TO (OR AS	A CONSEQUENCE	(S AK	D PHANT	KGEA				
CERTIFICATION	DUE TO (OR AS A CONSEQUENCE OF):								6 MONTHS	
PHYSICIAN: MEDICAL CI		INFECTED DE CUBITI					AM CC OF	RE AUTOPSY FINDINGS AILABLE PRIOR TO MMPLETION OF CAUSE DEATH? YES 2 NO		
IAN	25. WAS CASE REFERRED TO MEDICAL		26, PLACE OF D		_	IN L				
YSIC	EXAMINER?	HOSFITAL: 1 Inpetient 2 - ER/Ou			Home 5 Residence	6 🗆 Oth	er (Specify)			
ву рн	27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	28e. DATE OF INJURY (Month, Day, Year)		INJURY	WORK?	28d. DE	SCRIBE HOW IN	JURY OCCU	RED	
	2 Accident 3 Suicide 4 Homicide 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 28e. PLACE OF INJURY — At home, ferm, street, factory, office City or Town, State)						e Number,			
COMPLETED	Tonoch chilly &									nd manner ae steted.
TO BE C	SIGNATURE AND TITLE OF CERTIFIE	torange	le	M.DI			6			onth, Day, Year) - 1995
	U and	O COMPLETED CAUSE OF D		ype, Print) MAD	, 3015	T PAL	IL PLI	9CE	BAL	TIMONE M:
	31. DATE FILED (Month, Day, Year) NOV 0 81995	32. REGISTRAR'S SIG	SNATURE COLUMN							

8. BIRTHPLACE (State o

Michigan

1995

9c. COUNTY OF DEATH Anne Arundel

1916

3. TIME OF DEATH

Approximate interval Between

Onset and Death

24b, WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO

REG. NO.

2. DATE OF OEATH MONTH DAY

November

7. DATE OF BIRTH (Month, Day, Year)
May 28,

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

214 03 4294

4. SOCIAL SECURITY NUMBER

Bertha

1 M 2 K F

5. SEX

2, 3 shou	TOR	133 Jack Pine Drive				Pasadena				Anne Arundel		
permit. Pages 1,	DIRECTOR	100. STATE 10b. COUNTY Maryland N/A				wn or Locat imore	ION					INSIDE CITY LIMITS? YES 2 NO
ısıt	FUNERAL	100. STREET AND NUMBER 603 Jeffrey Stre	eet			10f	21225			10g. CITIZEN	OF WHAT	COUNTRY?
ding physician. The burial-transit	В	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER I FORCES? 1 YES IF YES, GIVE WAR OR D	2 🔀 NO	ED)	It yes, spe	ENDENT OF NISPANI ecity Cuben, Mexicen 2X NO Specify:			or No 14.	Black, Wh Specify:	Mericen Indian, lte, etc.
al or attending for use as the	LETED	15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12)	ATION completed) College (1-4 or 5+)	(Give life. D	EDENT'S USUA kind of work of Do NOT use retir	one during mo				NESS/INDUST	RY	
he hospital detached fo once.	TO BE COMPL	17. FATNER'S NAME (First, Middle, Last)								urneme)		
e 6 may be retained by t ector, page 5 should be must be notified at			unknown)			Helen Gawor						
		196. INFORMANT'S NAME (Type/Print) Bernadine Robacl		MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 133 Jack Pine Drive Pasadena, Maryland 211							21122	
		20e. METHOD OF DISPOSITION 1 © Burlel 2 Cremation 3 Remo 4 Donetion 5 Other (Specify)	vel from State Cer		etory or other parantal	aus Ce	metery	11/7		ation — city timore		ryland
ter death. Pag the funeral dir yval.		21. SIONATURE OF FUNERAL SERVICE LICE	, !/		George	o ADDRESS OF FAC E J. Gond Ritchie H	e Fun				21225	
eath certificate be executed within 74 hours after attending physician and completely filled in by th ttal Hygiene prior to burial, cremation, or remova y, or other traumatic event, the medical	CERTIFICATION	shock, or heart failure. L IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditiona, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO OR AS DUE TO OR AS	A CONSEOU	JENCE OF): JENCE OF): JENCE OF):	om	a Tho	ben	90 80%	dise	an	Approximate interval Between Onset and Des 9 mon Years Sept 9:
requires that the deen signed by the of Health and Mershows any Injury	MEDICAL C	PART II. Other algorificant conditions DID TOBACCO USE CONTR						_ 1	PERFORM	ED?	AVAI CON OF I	RE AUTOPSY FINDING ILABLE PRIOR TO MPLETION OF CAUSE DEATH? YES 2 NO
t: The law cate has to State Dept item 23	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			HER:						
PHYSICIAN this certifi with the s	РНҮ	1 YES 2 DANO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation	1 inpatient 2 ER/Out 28e. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY	28c. INJ WO M 1 1	URÝ AT DRK?			JURY OCCUR	EO	
DR ATTENDING FOR DIRECTOR: After hours after death tem 28 is mar	TED BY	2 Accident 3 Suicide 6 Could not be 4 Homicide determined	26e. PLACE OF INJUR building, etc. (Spe	Y — At home	e, term, street	, tectory, offic	•		ON (Street an own, Stete)	nd Number or	Rural Route	Number,
単 22年	COMPLETE	0001	CIAN: To the best of my know								euse(e) end	I menner se stated.
TO THE HOSPITAL TO THE FUNERAL De filed within 72 IMPORTANT: If	BE	29b, SIGNATURE AND TITLE OF CERTIFIER	y ale	da	- 1	MD	29c. LICENSE NUM D 390	SER 41		≥9d. DATE 6	D3	795
7	10	30. NAME AND ADDRESS OF PERSON WHO	AGADDA	EATH (ITEM	27) (Type, Print	H0	spita	Cer	Te	vert 1 B	att	-tetzi

MOV 0 81995 John Mariam Rock M

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE **CERTIFICATE OF DEATH**

IF UNDER 1 YEAR

DAYS

MONTHS

IF UNDER 24 HRS.

HOURS

Cichowicz

6. AGE (In yrs. last birthday)

79

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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE		
OFFICIOATE OF DEATH		

	1 - STATE REGISTRAR		AND / DEPAR CERTIF	ICATE OF	DEATH	REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH DAY		3. TIME OF DEATH	
	CHARLES H. ((In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	NOV. 5	1995	6:45 a. THPLACE (State or Foreign	
	215-09-5661	1 🖾 M 2 🗆 F	81 YRS.	MONTHS DAYS	HOUSE AND	(Month, Day, Year) 8/18/14	Cour	ntry)	
	Sa. FACILITY NAME (If not institution, give	street and number)	OT	9b. CITY, TOWN	OR LOCATION OF DEA		9c. COUNTY OF	imore, MD.	
TOR	Ft. Howard Vet	terans Hospit	al	Ft. Hov			Baltim		
DIRECTOR	10a. STATE 10b. COUNT Maryland N/A			ry, town or Local	TION			10d. INSIDE CITY LIMITS? 11 YES 2 NO	
AL.	10e. STREET AND NUMBER				H. ZIP CODE		10g. CITIZEN OF	WHAT COUNTRY?	
띨	432 Annabel Ave	enue			21225		U.S.	Α.	
BY FUNER	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	N U.S. ARMED 2 NO ATES II	If yes, sp	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No— If yea, specify Cuban, Maxican, Puerto Rican, etc.) 1 YES 2 NO Specify: 12. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No— If year, etc.)					
	15. DECEDENT'S EDI (Specify only highest grad	JCATION le completed)	USUAL OCCUPATION	ON opt of working	18b. KIND OF BUSH	NESS/INDUSTRY			
9	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT u	se retired.)	ost of working	D.C.O.	Ded Lace	a	
COMPLET	12th 17. FATHER'S NAME (First, Middle, Last)		Clerical B & O Railroad 18. MOTHER'S NAME (First, Middle, Mailden Surmame)						
- 11		Charles A. Ca	amphell	18. MOTHER'S NAME					
BE	19a. INFORMANT'S NAME (Type/Print)					ute Number, City or Town,			
2	Mildred Mewsha	W		st Avenu		imore, Mar		21225	
	20a. METHOD OF DISPOSITION 1 Surlai 2 Cremation 3 Ren	20b	PLACE AND DATE	OF DISPOSITION (N	ame of	DATE 20c. LOCA	ATION — City or 1	Town, State	
	4 Donellon 5 Other (Specify)		Baltimore				timore,	Maryland	
	21. SIGNATURE OF FUNERAL SERVICE LI		/	GOTO	ND ADDRESS OF FACILITIES TO GO TO	e Funeral	Home P	. A .	
	flome 1	namuouu	Me		Ritchie H			Md. 21225	
	23. FART i. Enter the diseases, or shock, or heart fallure.	complications that caused List only one cause on e	d the death. Do i	not enter the mo	ode of dying, auch	ss cardiac or reapire	itory srrest,	Approximate	
	IMMEDIATE CAUSE (Final							Onset and D	
	disease or condition resulting in death)	METASTATIC			TO LIVER			1 1/2 M	
_	PANCREAS CARCINOMA								
	Sequentially list conditions, If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):								
<u>8</u>	cause. Enter UNDERLYING CAUSE (Disease or Injury	c							
RTIFICATION	that initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE O	F):					
CER	Todating in death) Exo	d							
7	PART II. Other significant condition	ns contributing to death b	ut not resulting	in the underlyin	g cause given in Pr	PERFORM	b. WERE AUTOPSY FINDS AVAILABLE PRIOR TO COMPLETION OF CAUS		
MEDIC						1 TYES 2	0 ио	OF DEATH?	
2	DID TOBACCO USE CONT	RIBUTE TO CAUSE O	F DEATH YE	S \square NO \square	UNCERTAIN	TO 1		1 TES 2 NO	
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEA						
š	1 TES SONO	HOSPITAL: 1 M Inpetiant 2 - ER/Outp	etlent 3 🗆 DOA	OTHER: 4 Nursing Hom	ne 5 🗆 Rasidence 8	Other (Specify)			
E	27. MANNER OF DEATH 1. Natural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b. TIM		JURY AT 2	ed. DESCRIBE HOW INJ	JURY OCCURED		
à l	2 Accident Investigation				YES 2 NO				
	3 Suicide 8 Could not be 4 Homicide detarmined	28e. PLACE OF INJURY building, etc. (Spec	ia 2	281. LOCATION (Street and City or Town, State)	d Number or Rural	Route Number,			
	29a. CERTIFIER	SICIAN: To the best of my knowl	ledge, death occurr	ed at the time, data	and place, and due to	the cause(a) and manne	er as stated.		
PLET	(Check only 1 CERTIFYING PHYS			n, In my opinion, d	leath occured at the tir	me, deta and pieca, and	due to the cause	(a) and menner as stete	
OMPLET		ER: On the basis of examination	n and/or investigatio						
	2 MEDICAL EXAMINE 29b. SIGNATURE AND TITLE OF CENTRIE	ER: On the basis of examination	n and/or investigatio		29c. LICENSE NUMB	ER :		Q (Month, Day, Year)	
H	29b. SIGNATURE AND TITLE OF CERTIFIE	ER: On the basis of examination			D4514	ER 2	NOVEM	Q (Month, Day, Year)	
TO BE COMPLETED	29b. SIGNATURE AND TITLE OF CERTIFIE 30. NAME AND ADDRESS OF PERSON WI	ER: On the basis of axamination	АТН (ITEM 27) (Туре,	Print)	D4514	8	Novem	o (Month, Day, Year) bfr S1199	
띪	29b. SIGNATURE AND TITLE OF CERTIFIE	ER: On the basis of axamination	ATH (ITEM 27) (Type, 9600 NO	Print)	D4514	ORT HOWARD	Novem	o (Month, Day, Year) DFT S 199	

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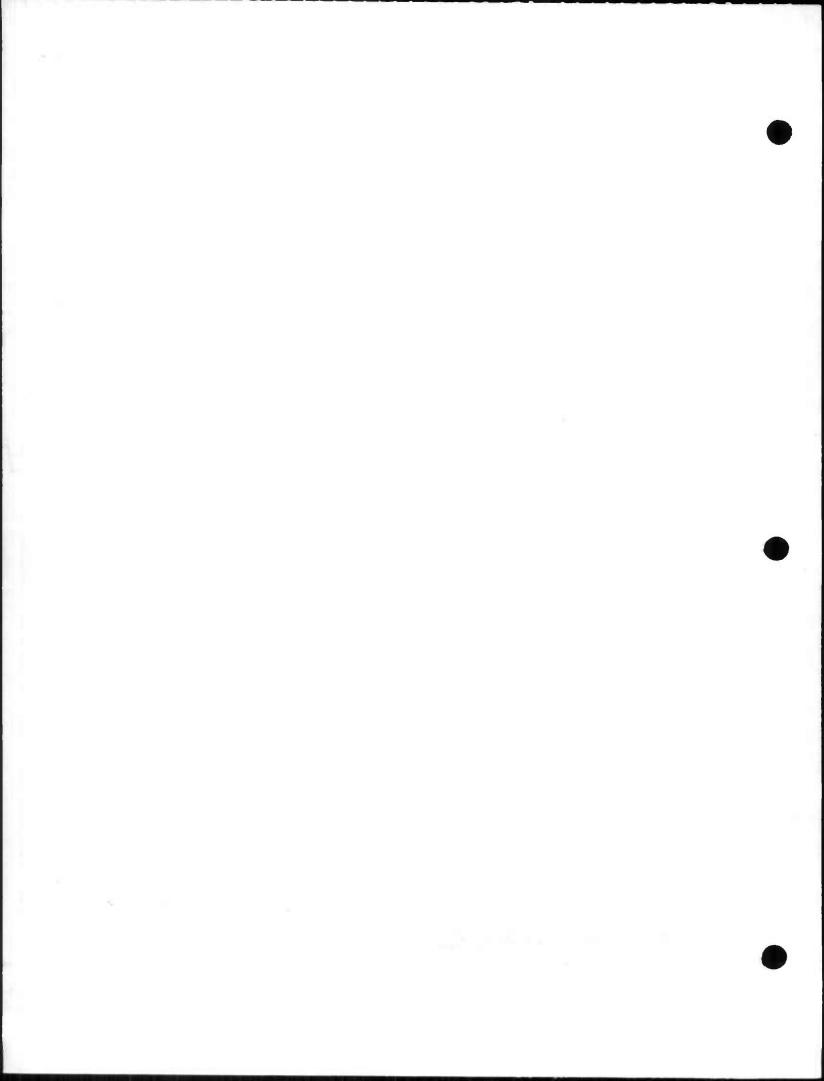
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O THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	MPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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asp					20	00000					
1 - FOR STATE REGISTRAR	STATE OF MARYL		MENT OF HEALTH AND	MENTAL HYGIEN REG. NO.	E						
1. DECEDENT'S NAME (First, Middle, Last) CARL	N.		CRENSHAW		27 199!	A					
4. SOCIAL SECURITY NUMBER 229 58 6612	1 X XM 2 □ F	46 YRS.	F UNDER 1 YEAR	7. DATE OF BIRTH (Month, Day, Year) 1 9 194	49 RIC	HMOND, VA.					
99. FACILITY NAME (If not institution, give 1226 MOSHER S			BALTIMORE CI								
1226 MOSHER S RESIDENCE OF DECEDENT 100. STATE 10b. COUNT MARYLAND	Υ		TOWN OR LOCATION			10d. INSIDE CITY LIMITS? 1X Xyes 2 NO					
104. STREET AND NUMBER											
3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? t YES IF YES, OIVE WAR OR D	2 X NO	13. WAS DECENDENT OF HISP, If yes, specify Cuben, Mark 1 YES 2 NO Speci	can, Puerto Ricen, etc.)	Bla	CE — American Indian, ck, White, etc.					
15. DECEDENT'S EDI (Specify only highest grad Elementary/Secondary (0-12) 12TH	completed) College (1-4 or 5+)	18a. DECEDENT'S US (Give kind of wor life. Do NOT use i	k done during most of working retired.)	CONSTRI	SINESS/INDUSTRY						
17. FATHER'S NAME (First, Middle, Last)	1 YR.	LADO		IAME (First, Middle, Melden							
190. INFORMANT'S NAME (Type/Print) JOHN PATTERSON	Ī		DRESS (Street and Number or Rura CAREY STREET	217							
20e. METHOD OF DISPOSITION 1) Department of Disposition Rer 4 Donation Donation Other (Specify)		b. PLACE AND DATE OF	DISPOSITION (Name of CEMETERY		CATION — City or BALTO.						
21. SIGNATURE OF FUNERAL SERVICE L	P. Carrol	0_	IRVIN P. C.	ARROLL FU							
	disease or condition										
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF):										
PART II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Pert I. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 Inpertion 2 ER/Outpatient 3 DOA A Nursing Home Residence 6 Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. INJURY WORK?											
DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	28. PLACE OF DEATH	(Check only one)								
1X YES 2 NO 27. MANNER OF DEATH 1 V Netural 5 Pending	1 Inpatient 2 ER/Out 28s. DATE OF INJURY (Month, Day, Year)	patient 3 DOA 4	OF 28c. INJURY AT WORK?	e 6 Other (Specify) 28d. DESCRIBE HOW I	INJURY OCCURED						
2 Accident Investigation	28a. PLACE OF INJUR	Y — At home, farm, atractly)	M 1 TES 2 NO		281. LOCATION (Street and Number or Rural Route Number, City or Yown, State)						
TOTAGES OTHY			at the time, data and place, and d			e(a) and manner as stated.					
296. SIGNATURE AND TITLE OF CERTIFI	4. Ch.	to us	29° LICENSE N	UMBER L		ED (Month, Day, Year) BER 28, 199					
30. NAME AND ADDRESS OF PERSON W	POMPLETED CAUSE OF D	EATH (ITEM 27) (Type, F	nn Street, I	Baltimore	, Maryl	and 21201					
31. DANOUT (Jont/801995	32. SEGISTRAR'S SU	NATURE .									



hours after death. Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

		REGISTRAR	CERTIFICATE OF DEATH							REG. NO.		
		1. DECEDENT'S NAME (First, Middle, Last) ANTHONY	JOSEPH		CYRA	N		2. DATE ON NOV .	F DEATH DA	* 1995 [*]	(EAR 3.	TIME OF DEATH 12:30 P. M
		4. SOCIAL SECURITY NUMBER 213-16-9431	5. SEX 6. AC	GE (In yrs. le 74		IF UNDER 1 YE	AR IF UNDER 24 HRS.	7. DATE OF Sept	BIRTH Day, Year)	1921	BIRTHPL/ Country)	ACE (State or Foreign
pino		9s. FACILITY NAME (If not institution, give st	reet and number)			9b. CITY. TO	WN OR LOCATION OF D		,	9c. COUNTY		
1, 2, 3 should	TOR	324 S. Patterson					to. City,					City
	DIRECTOR		lto. City		10c. CITY,	Balto	City					d. INSIDE CITY LIMITS?
sit permit		10. STREET AND NUMBER 324 S. Patterson	Park Ave.				101. ZIP CODE 21231		10g. CITIZEN OF WHAT COUNTRY?			T COUNTRY?
the burial-fransit permit. Pages	BY FUNERAL	11. MARITAL STATUS t Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVE FORCES? 1 YOU IF YES, GIVE WAR OF						IGIN? (Specify Yes or No— 14. RACE — Americ Black, White, at Specify White, at			Thite, atc.
for use as		15. DECEDENT'S EDUC (Specify only highest grade		16a. Di	ECEDENT'S U	SUAL OCCUI	PATION g most of working	16b, K	IND OF BUS	SINESS/INDUS		
iched for	COMPLETED	Elementary/Secondary (0-12) 10 th	College (1-4 or 5+)	- 1	re Cl			P1:	umbin	g Supp	lies	
5 should be detached notified at once.	ш	17. FATHER'S NAME (First, Middle, Last) Joseph P. Cyrai	n				18. MOTHER'S NAME (First, Middle, Melden Surmame) Laura A. Lisiecki					
5 should notified	8	19e. INFORMANT'S NAME (Type/Print)		19	b. MAILING /	ADDRESS (Str	eet and Number or Rural	Route Number	City or Town	n. State Zio Co	odel	
be not	5	C _{ecelia} Zielski			424 S	. Was	hington St	. Ba	lto.	MD. 21	1231	
irector, p		20s, METHOD OF DISPOSITION ABoriel 2 Cremation 3 Remo 4 Donation 8 Other (Specify)	oval from State		ROSAT			11-8		cation – cin nda1k		State
e funeral d al. examine		21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Charlton F.H. 2007 Eastern Ave. Balto. 21231										
mpletely filled in by to cremation, or remover the medical control of the medical control o		23. PART I. Enter the diseases, or canock, or heart feliure. I iMMEDIATE CAUSE (Final disease or condition resulting in death)	List Only one ceuse or	pee pee	ecta	eep	mode of dying, suc			ratory arrest	t,	Approximate Interval Between Onaet and Death
the attending physician and completely filled in by the funeral director, page 1 Mental Hygiene prior to burial, cremation, or removal. Injury, or other traumatic event, the medical examiner must be in	ERTIFICATION	Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST b. DUE TO (OR AS A CONSEQUENCE OF): C. DUE TO (OR AS A CONSEQUENCE OF): d.										
Wenta Jury,	ပ	PART II. Other aignificent condition	L contributing to deat	hut not	requiting in	the under	hulaa aassa atsaa ta	Beat La				
ith and	EDICAL				ide		ying cause given in		PERFOR	MED?	CO	RE AUTOPSY FINDINGS AILABLE PRIOR TO MPLETION OF CAUSE DEATH?
ficate has been significate Dept. of Healt Item 23 shows	Ξ	DID TOBACCO USE CONTR	RIBUTE TO CAUSE	OF DEA	TH YES	□ NO	☐ UNCERTAII				10	YES 2 NO
e has	¥.	25. WAS CASE REFERRED TO MEDICAL. EXAMINER?		28. PLAC	CE OF DEATH	(Check only	one)				_	
he State or Item	Si	1 YES 2	HOSPITAL: 1 Inputient 2 ER/O	utpatient 3		OTHER:	Home 5 - Realdence	8 Other (S	Specify)			
with t	BY PHYSICIAN:	27. MANNER OF BEATH Natural 5 Pending Pen	28a. DATE OF INJUF (Month, Day, Yea		28b. TIME INJU	OF 28c	INJURY AT WORK?			NJURY OCCUR	IED	
after d	8	3 Suicide 8 Could not be detarmined	28a. PLACE OF INJU building, atc. (S	IRY — At he pecify)	ome, farm, str	eet, tectory,	office	28t. LOCATI City or	ON (Street a Town, State)	ind Number or i	Rural Route	Number,
4 Z =	COMPLET	29e. CERTIFIER (Check only one) t CERTIFYING PHYSIC 2 MEDICAL EXAMINER	CIAN: To the best of my kn	owledge, de	eath occurred	at the time, In my opinio	data and place, and due	to the cause	(a) and man	ner as stated.	suse(s) sn	d menner as stated.
TO THE FUNER DE filed within IMPORTANT.	BE	296. SIGNATURE AND TITLE OF CERTIFIER	ei MT				29c. LICENSE NUM	BER 74	8	29d. DATE SI	IGNED (MO	orth, Day, Year)
	5	ANIL UBONO	COMPLETED CAUSE OF	DEATH (ITE	M 27) (Type, F	rine)	BAL	70 1	nD.	2121	1	
		NOV 0 8 1995	32, REGISTRAR'S SI	GNATURE							,	

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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	-	FilmG, 730, item #4, 12/11/95 FOR STATE OF MARYL STATE REGISTRAR	AND / D	EPARTMENT	OF HEALTH AN OF DEATH		L HYGIEN	E				
	F.	t. OECEOENT'S NAME (First, Middle, Last) WADE S. CORNOG	OLI	THIOAIL	OI DEAIII	2. DATE	OF DEATH		YEAR	3. TIME OF DEATH		
	ı	5.		NOV		, 19	95	7:13 A M				
		. 414-84-3194	(In yrs. lest bit			RS. 7. DATE (Mont	of Birth h, Day, Year) y 26,1	Day, Year) Count		PLACE (State or Foreign		
	1	9e. FACILITY NAME (If not institution, give street and number)		9b. CITY, T	OWN OR LOCATION				TY OF DE	EATH		
TOR	201	100 WEST EAGER STREET		BAI	TIMORE	CITY			N/A			
DIRECTOR	JIME.	10a. STATE 10b. COUNTY Md N/A	1	Baltime						10d. INSIDE CITY LIMITS?		
		10e. STREET AND NUMBER		Dallin	10f. ZIP CODE			I som CITIS		1 X YES 2 NO		
FIINFRAI	8	855 Park Avenue				201		log. Citta	USA			
Z	<u> </u>	11. MARITAL STATUS 12. WAS DECEDENT EVER I	IN II S ADME	D 12 W	S DECENDENT OF H		V2 (Encelly Voc	or No. T		- American Indian.		
>	5	1 Never Married 2 Married 3 Widowed 4 Divorced TORCES7 1 YES IF YES, GIVE WAR OR D	2y NO	If y	res, specify Cuben, M	lexicen, Puerto		TOP NO.	Black, Specif	White, etc.		
6	3	15. DECEDENT'S EDUCATION (Specify only highest grade completed)		DENT'S USUAL OCC		180	. KIND OF BUS	SINESS/IND	USTRY			
L	. I	Elementary/Secondary (0-t2) College (1-4 or 5+)	ille. Do	o NOT use retired.)	my most or working							
COMPL		9	Lig	ghting D	irector		Musi	c Sho	WS			
3 5	3	17. FATHER'S NAME (First, Middle, Last)				'S NAME (First,						
H.		Charles A. Cornog				ey L.						
9		19a, INFORMANT'S NAME (Type/Print)	n, State, Zip	Code)								
	-	Shirley Madsen 18 Torlina Court, Woodlawn, Md.										
		20b. METHOD OF DISPOSITION 1 District 2 Cremation 3 Removal from State 4 Donetion 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of carried parts). Cremation 2 Checked parts. Cremation 2 Checked parts. Cremation 2 Other (Specify) 21. SIGNAPUNE OF FUNERAL SERVICE LICENSEE 22b. PLACE AND DATE of DISPOSITION (Name of carried parts). Cremation (Name of carried parts). DATE carried parts. City or Town, State carried parts. City or Town, City or Town, State carried parts. City or Town, City or Town, State carried parts. City										
_		23. PART I. Enter the diseases, or complications that ceuse	Nooo	Bra	dley Ash	ton Fu						
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		ahock, or haart fallure. List only one cause on of IMMEDIATE CAUSE (Final disease or condition resulting in death) A HANGING Due to (or as	each lina.	h. Do not enter ti	4 Willow ne moda of dying,	Sprin auch as car	g Road disc or respi	Dun ratory arr	est,			
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3	. 11	ahock, or haart failure. List only one cause on a limited state of the list of	A CONSEQUE A CONSEQUE A CONSEQUE Dut not rasis	ENCE OF): ENCE OF): ENCE OF): Ulting in the under the	eriying cause giva	in In Part I.	24a. WAS AN PERFOR	AUTOPSY MMED?	24b.	WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? XYES 2 NO		
RY PHYSICIAN: MEDICAL CERTIFICATION	PHTSICIAN: MEDICAL	ahock, or haart failure. List only one cause on displacement of the failure displaceme	A CONSEQUE A CONSEQUE A CONSEQUE Dut not rast DF DEATH 26. PLACE of the perior to 3 12 12 12 12 12 12 12 12 12 12 12 12 12	ENCE OF): ENCE OF): ENCE OF): Utiling in the undiding in th	erlying cause give O UNCER by one) g Home 5 Reelde sc. INJURY AT WORK? 1 YES 2 Y N	TAIN Dence & X Other	24a. WAS AN PERFOR	AUTOPSY MED?	24b.	Approximate Interval Batween Onset and Death Onset and Death Were autopsy Findings Applicable Prior TO Completion of Cause of Death? XYES 2 NO		
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30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

111

FOWLER

DR.DAVID FO

Penn Street, Baltimore, Maryland 21201

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

The FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR

1

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	CAROL		CLAR	K		2. DATE OF DEATH MONTH DAY YEAR 1995 2. OA 1						
			(In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	10.6	NRTHPLACE (State or Foreign				
	216-38-7263 9s. FACILITY NAME (If not institution, give stree	□ M 2 XXXF	57 YRS.			April 28	1938 ĭ	MARYLAND				
DIRECTOR	4001 NORTHERN PAR				IMORE CI		9c. COUNTY OF DEATH					
JEC.	10s. STATE 10b. COUNTY		10c. CITY,	TOWN OR LOCA	TION		10d. INSIDE CITY					
	MARYLAND N//	Α			ORE CITY		LIMITS? 1X X YES 2 □ NO OF WHAT COUNTRY?					
FUNERAL	4001 NORTHERN PAR				21215		A.					
BY FU	1 Never Married 2 Married 3 Widowed 4 XXDivorced	N U.S. ARMED 2 NO PATES	NO If yes, specify Cuben, Mexican,			NIC ORIGIN? (Specify Yes or No— in, Puerto Ricen, etc.) 14. RAC Blec Spec						
ED	15. DECEDENT'S EDUCAT (Specify only highest grade co.	FION	16a. DECEDENT'S U	SUAL OCCUPATI	ON	16b. KIND OF BU	SINESS/INDUST	BLACK				
COMPLETED		College (1-4 or 5+)	HEALTH			HEAL	.TH					
00	17. FATHER'S NAME (First, Middle, Lest)				18. MOTHER'S NAI	ME (First, Middle, Maiden	Surname)					
BE (Henry White					a Campbell						
2	19s. INFORMANT'S NAME (Type/Print) Rodney Clark					oute Number, City or Tow y Apt B4,		21215 ore, Maryland				
	20e, METHOD OF DISPOSITION Burlel 2 Cremation 3 Remove 4 Donstion 6 Other (Specify)	al from State	NAME OF THE PROPERTY OF STATE OF THE PROPERTY OF	MORIAL	PARK	11/10 E		RE, MARYLAND				
	21. SIGNATURE OF FUNERAL SERVICE LICEN	1										
-	23. PART I. Enter the disesses, or con	nolications that cause	the deeth Do no		W. NORTH							
	shock, or heart failure. Lie IMMEDIATE CAUSE (Final	of only one cause on e	ach line.	t dittor the fire	de of dying, suci	r as cardiac or reap	iratory strest,	Approximats Interval Between Onset and Death				
	disease or condition - a. CANCER OFTHE LUNG WITH BONE HEMSTASES 9 MONTHS											
į	DUE TO (OR AS A CONSEQUENCE OF):											
ON	Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF):											
₹ I	if any, isading to immediate cause. Enter UNDERLYING CAUSE (Disesse or injury		,									
CERTIFICATION	that initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF):									
S	d											
MEDICAL	PART II. Other algnificent conditions	TUS SAC		the underlyin	g ceuse given in i	Part I. 24a. WAS AN PERFOR		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO				
ED		1103 =170	-AUN-			1 TES 2	NO NO	COMPLETION OF CAUSE DF DEATH?				
	DID TOBACCO USE CONTRIB	BUTE TO CAUSE O	F DEATH YES		UNCERTAIN			1 - YES 2 1 NO				
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEATH	(Check only one)		7-1						
YSi	1 YES 2 NO 1	Inpatient 2 ER/Outs	petient 3 DOA 4	OTHER:	e 5 🗆 Residence (6 Other (Specify)	tospice					
	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	26a. DATE OF INJURY (Month, Day, Year)	28b. TIME (TY WO	URY AT RK?	28d. DESCRIBE HOW I	NJURY OCCURE	D				
ED BY	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF INJURY building, etc. (Spec	— At home, farm, stre	eet, factory, offic		261. LOCATION (Street of City or Town, State)	and Number or Ru	iral Route Number,				
	29s. CERTIFIER	N. 7- 11-11-11-11										
COMPLET	(Check only 2 MEDICAL EXAMINER:							ise(s) and menner as stated.				
BE O	296. NGNATURE AND TITLE-OF CERTIFIER	0 11	/		29c. LICENSE NUM	BER		NED (Month, Day, Year)				
2	30. NAME AND ADDRESS OF PERSON WHO C	crown	ATAL CITTOR -		D 060	933	Nov	-6 1995				
	JOHN B	MACGIB	AIH (ITEM 27) (Type, P	nint)	/ WEST	REAN ST	RACT	MOLE 21201				
	NOV 16 (8 1995 ar)	RESTRA SIO	ATURE		, 10001	-511V -3 (.	SHUIM	- 21201				

Thursday watery to

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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5	DIRE	hours	item!
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THE HOSPITAL UR ALTENU) THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buris	filed	PORTANT: if item 28 is marked, or item 23 shows any loiury or other traumatic event, the medical examiner must be notifi-
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31. DNOVO (1008 1995

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	1 - FOR STATE REGISTRAR	STATE OF I	MARYLAND /	DEPAR	TMEN	T OF H	IEALTH DEAT	AND I	MENTAL HYGIEN				
	1. DECEDENT'S NAME (First, Middle, Last)								2. DATE OF DEATH	AY		3. TIME OF DEATH	
	DORIS CLAIRE	DYER							November		YEAR	3:15 PM M	
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. les	st birthday)		ER 1 YEAR	IF UNDER	-	7. DATE OF BIRTH		S, BIRTHE	PLACE (State or Foreign	
	144-18-5297	1 □ M 2 反 F	72	YRS.	MONTHS	DAYS	HOURS	MIN.	(Month, Day, Year) Mar 15, 19	Country)			
	9s. FACILITY NAME (If not institution, give s	treet and number)							923 New Jersey 1 sc. COUNTY OF DEATN				
R	707 Park Ave.			M	It. A								
5	RESIDENCE OF DECEDENT					IL. A	шу			La	rrol1		
H	10a. STATE 10b. COUNTY			10c. CIT	Y, TOWN	OR LOCA	ION					10d. INSIDE CITY LIMITS?	
₫	Maryland Carre	011		i	Mt.	Airy						1 VES 2 □ NO	
BY FUNERAL DIRECTOR	10e. STREET AND NUMBER			_		10	. ZIP CODE			10g. CIT	ZEN OF W	HAT COUNTRY?	
E	707 Park Ave.						2177	71		II	SA		
5	11. MARITAL STATUS	12. WAS DECEDEN	T EVER IN U.S. AR	MED	13	. WAS DEC	ENDENT O	F NISPAN	IIC ORIGIN? (Specify Ye			- American Indian, White, atc.	
Y	1 Never Married 2 Married	IF YES, GIVE V	YES 2 K	NO.			ecify Cubar 2 5 NO		n, Puerto Rican, etc.)		Black, Specify		
	3 🔀 Widowed 4 🗌 Divorced						**					White	
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade	CATION completed)	16a, DE	CEDENT'S	USUAL (OCCUPATIO	ON st of working	n	16b. KIND OF BU	SINESS/IN	DUSTRY		
Ш	Elementary/Secondary (0-12)	College (1-4 or 5	+) life.	Do NOT u	se retired.	Head	of working		Defense	Ind	ustry		
MP	12 years		Sec	urit	y Do	cume	nts S	ect	. Westing	hous	e		
8	17. FATNER'S NAME (First, Middle, Last)						18. MOTN	ER'S NA	ME (First, Middle, Meiden	Surname)			
BE (Bernard Sharkey							The	resa Bauer	band			
0	19a. INFORMANT'S NAME (Type/Print)		191	b. MAILING	ADORES	SS (Street a			Route Number, City or Tow		p Code)	97.0	
۴	Mr. Kenneth O. Dye	er	3	018 1	Mich	ael :	Rd.	Mt.	Airy,MD	217	7 1		
	20e. METHOD OF DISPOSITION 1 K Buriel 2 Cremetion 3 Remote Control Supports Support Control Support Support Control Support S	oval from State	20b. PLACE	AND DATE	OF DISPO	SITION (No	ma of		OATE 20c. LO	CATION -	City or Tow		
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE	- DC. re	cters	22	NAME A	D ADDRES	S OF FA	11-8 L1	perty	town,	MD	
	I Del V	1	0))		Βι	ırrie	r-Qu	een	Funeral Di	irect	ors,	P.A.	
	John 1	- 194y~	LU J		12	212 W	. 01	d_Li	berty Rd.	Winf	ield	MD 21784	
	23. PART Enter the diseases, or of ahock, or heart feiture.	complications that List only one cau	t caused the de	eth. Do i	not ente	r the mo	de of dyir	ng, auci	h ee cerdiec or reep	iratory er	reet,	Approximate interval Between	
	IMMEDIATE CAUSE (Finel		\							Onset end Death			
	disease or condition requiting in death)	· Car	giores	pintery Failure								394A>	
		DUE TO	(OR AS A CONSE	DUENCE O	F):								
Z	Convention that are divine	A. As	(OR AS A CONSEC	c- 1	Pne	4	iti					10911)	
ERTIFICATION	Sequentially list conditions, if any, leading to immediate												
2	cause. Enter UNDERLYING CAUSE (Disease or injury	a Pan	crestic	Ca	7666							9 mar the	
비	thet initieted eventa	DUE TO	(OR AS A CONSEC	DUENCE O	F):								
	readiting in death) Exs	d											
0	PART II. Other significent condition	a contributing to	deeth but not r	equiting	in the u	nderlula		luca la	Boot ! Los umo au	*******	Lan		
PHYSICIAN: MEDICAL	Chrinicanin			ouditing		indenty in i	couse g	IVOII III	Part i. 24a. WAS AN PERFOR			WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO	
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Σ	B =============									,		1 TES 2 NO	
ä	DID TOBACCO USE CONTE	EIBUTE TO CA	USE OF DEA	TH YE	S 🗆	NO D	UNC	ERTAIN	10				
5	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLAC	E OF OEA	OTHE								
YSI	1 YES 2 NO	1 - Inpetient 2 -	ER/Outpatient 3	□ DOA			5 X Res	idence	a Cother (Specify)				
표	27. MANNER OF DEATN 1 Voletural 5 Pending	28a. DATE OF (Month, D		28b. TIM	E OF	28c. INJ WO	HRY AT		28d. DESCRIBE NOW	NJURY OC	CURED		
B	1 Netural 5 Pending Investigation				M		'ES 2 🗌	NO					
	3 Suicide 8 Could not be	28e. PLACE O building,	F INJURY — At ho etc. (Specify)	me, larm,	Mreet, fac	ctory, office			281. LOCATION (Street a City or Town, State)		or Rural Ro	ute Number,	
	4 Nomicide detarmined												
7	29a. CERTIFIER Check only	CIAN: To the best of	my knowledge, de	ath occurr	ed at the	time, data	and place,	and due	to the cause(a) and mar	nner aa sta	ted.		
COMPLETED									time, data and place, an			and manner as stated.	
	29b. SIGNATURE AND TITLE OF CERTIFIER		1				29c. LICEI						
B	anx. m	July X	A									Month, Dey, Year)	
P 30, NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATH (ITEM 27) (And Policy)										כו"י			

DMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

THE PROPERTY SIGNATURE

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27044

(a) umbie

3. TIME OF DEATH

REG. NO

2. DATE OF DEATH

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First Middle Last)

1 -

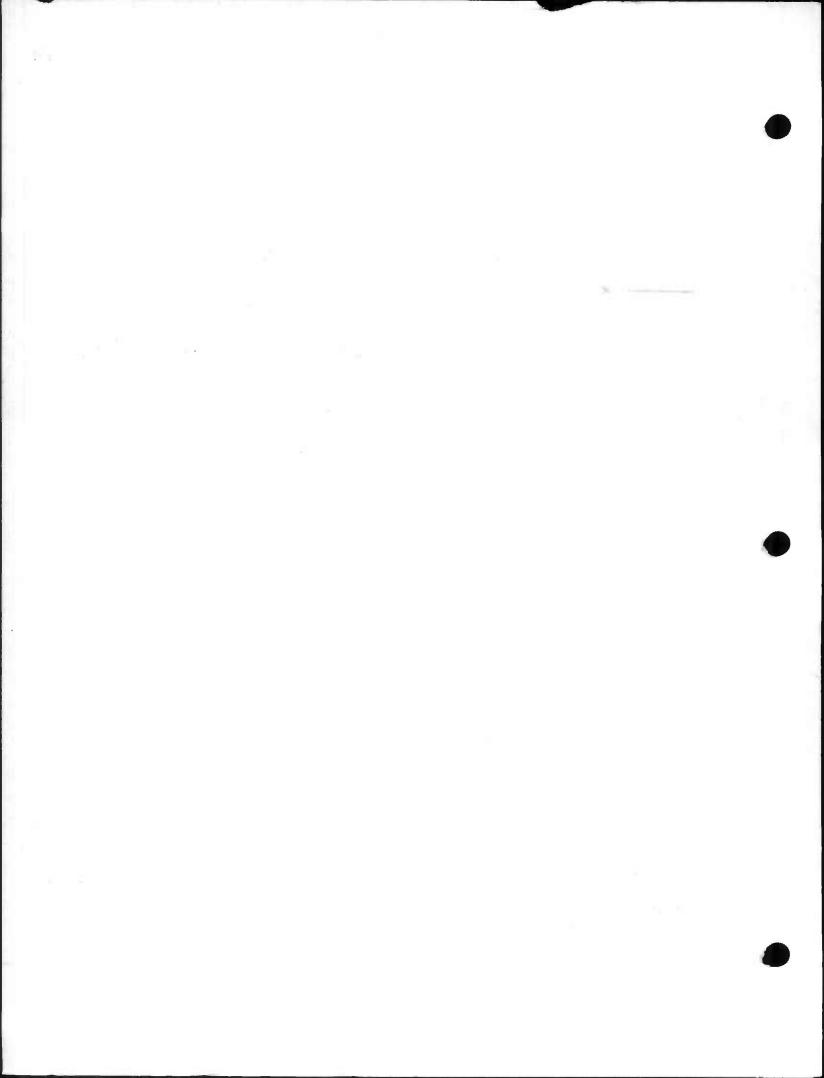
NOVEMBER 1995 00:57 ISAIAH ERVIN AM 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (MORIN Dell 7 er) 1932 a, BIRTHPLACE (State or For 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 217-24-1410 BATTIMORE, MD 63 XX M 2 D F DAYS HOURS MIN. bunal-transit permit. Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR BALTIMORE n/a CITY JOHN HOPKINS HOSPITAL RESIDENCE OF DECEDEN 10d. INSIDE CITY
V LIMITS?
1 YES 2 NO 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION MARYLAND BALTIMORE n/a FUNERAL 16e. STREET AND NUMBER 10f. ZIP CODE WHAT COUNTRY? STATES UNITED DALLAS 21231 215 COURT N. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 WHO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No- RACE — American Indian, Black, Whita, atc. FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES If yes, specify Cuban, Mexican, Puarto Rican, etc.) Named 2 Married 1 TYES 2 XIO Specify Specify: BY **BLACK** the 3 Widowed 4 Divorced for use as COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) 10 STEEL WORKER detached th various companies once. 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Malden Surname) page 5 should be To WILLIAM ERVIN **OPHELIA** MOBLEY BE notified a 19a. (NFORMANT'S NAME (Typo/Print) ROSALIND 3913 WABASH AVENUE, APT. 1B, BALTIMORE, MD# 15 2 **ERVIN** pe 200. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION /Name of 20c. LOCATION - City or Town, State DATE must 1 Pauriat 2 Cremation 3 Ramovat from State funeral director, 4 Donation 5 Other (Specify) WESTERN STAR CEMETERY 11 - 10CATONSVILLE, MD medicai examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY WM. C. MARCH FH.-1101 E. NORTH **AVENUE** the in by the 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert fellure. List only one ceuse on each line. Interval Between 6 filled Onset and Death IMMEDIATE CAUSE (Final cremation, the of the Head diseese or condition Wound Gunshot completely resulting in death) traumatic event, DUE TO (OR AS A CONSEQUENCE OF) bunal CERTIFICATION and Sequentially list conditione, DUE TO (OR AS A CONSEQUENCE OF) prior to If any, leading to immediate cause. Enter UNDERLYING other 1 CAUSE (Disease or Injury the attending physical I Mental Hygiene p DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in deeth) LAST 5 injury, PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS been signed by the AVAILABLE PRIOR TO any COMPLETION OF CAUSE 1 YES 2 NO OF DEATH? Shows 1 NY YES 2 1 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO M. UNCERTAIN N PHYSICIAN: has be Dept. 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) certificate the State I, or item EXAMINER?

YES 2 NO

27. MANNER OF DEATH HOSPITAL: OTHER:
4 | Nursing Home 5 | Residence 6 | Other (Specify) 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED this co marked, 1 Natural 5 Pending Investigation 11-5-95 222FpM 1 YES 2 NO ect shot BY After 2 Accident 281. LOCATION (Street and Number or Rural Route Number, City or Town, Steete) 2100 Mura. Street 3 Suicide 28a. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) THE HOSPITAL OR ATTENDIN THE FUNERAL DIRECTOR: Af if fled within 72 hours after de 60 ETED 6 Could not be 4 K Homicide 28 Street Baltimore, nd Hem 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, end due to the cause(e) end menner as attend. COMPL Man. 2 MEDICAL EXAMINER: On the beels of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated. IMPORTANT 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE Chrite no NOVEMBER 6,1995 O.C.M.E. 223 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 2 CHUTE DENNIS Penn Street, Baltimore, Maryland 21201 32 HEBST Whole To He Randelle

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH



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ATTENDING PHYSICIAN; The law requires that the death certificate be executed within 24 hours after death, Page 6 may be	CTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page
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	1. DECEDENT'S NAME (First, Middle, Last)		ERTIFICATE OF	DEATH	REG. NO		
ľ	NORETTA	ELLIOTT			2. DATE OF DEATH	1995 ^{EAR}	3. TIME OF DEATH 9:00 P
1	4. SOCIAL SECURITY NUMBER 245-22-2119	5. SEX 6. AGE (In yrs. le	YRS. MONTHS DAYS	IF UNDER 24 HRS. HOURE MIN.	7. DATE OF BIRTH (Month, Day, Year)	20 100	HPLACE (Store or Foreign try) The Caroline
DIRECTOR	90. FACILITY NAME (If not institution, give st UNIVERSITY RESIDENCE OF DECEDENT	Hospital	13al	LOCATION OF DE		9c. COUNTY/OF	DEATH 4
	10a. STATE 10b. COUNTY	NA	10c. CITY, TOWN ON LOCA	nore			10d. INSIDE CITY LIMITS? 1 VES 2 NO
FUNERAL	2807 W. NO	THE QUE		2/2/6	ORIGIN? (Specify Yes	US	E – American Indian,
D BY F	1 Never Married 2 Merried 3 Widowed 4 Divorced	FORCES? 1 YES 2 DIF YES, GIVE WAR OR DATES	NO If yes, sp		n, Puerto Rican, atc.)	Blac	ck, White, atc.
ETE	15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12)		ECEDENT'S USUAL OCCUPATION of white downing me of population of white downing me of population of the	ON sst of working	16b. KIND OF BU!	Serv	ICE
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5	199, INFORMANT'S NAME (Type/Print) 201. NETHOD OF DISPOSITION	er Jr,	AND DATE OF DISPOSITION (N	lorth (ive. Ba	Ho.Md.	21216
	1 Burlet 2 Cremetion 3 Remoted Donation 5 Other (Specify) 21. Signature of Funeral Service Lice	val from State emetery, cr	PROFEST CHL	TCh Cem	145101	MINGTO Baltimo	n. N.C re. md.
	23. PARY I. Enter the diseases, or c	omplications that caused tha d	eath. Do not enter the mo	2 W. n	offi ave	Q12	1 Approximats
	iMMEDIATE CAUSE (Final disease or condition resulting in death)	OVERWHELING	SEPSIS				Onset and Dast 5 DAYS
_		CHOLANGIOMA	OUENCE OF):				5 MONTH
RTIFICATION	Sequentially list conditions, if any, lasding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury	DUE TO (OR AS A CONSE	OUENCE OF):				
CERTIF	that initiated events resulting in death) LAST	DUE TO (OR AS A CONSE	OUENCE OF):				
EDICAL (PART II. Other aignificant conditions	contributing to death but not	resulting in the underlying	g cause given in	Part I. 24e. WAS AN PERFOR	MED?	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE
Σ	DID TOBACCO USE CONTR	IBUTE TO CAUSE OF DEA	ATH YES NO	UNCERTAIN			OF DEATH? 1 ☐ YES 2X NO
SICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2X NO	26. PLA/	OTHER:	Or provide a			
ву рну	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	28e. DATE OF INJURY (Month, Day, Year)	26b. TIME OF 28c. INJ	URY AT HK?	28d. DESCRIBE HOW II	NJURY OCCURED	
ETED E	3 Suicide 8 Could not be determined	26e. PLACE OF INJURY — At he building, atc. (Specify)	ome, farm, street, fectory, offic		281. LOCATION (Street e City or Town, State)	nd Number or Rural i	Route Number,
COMPLI	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSIC 2 MEDICAL EXAMINER	IAN: To the beat of my knowledge, do : On the basis of examination end/or	eath occurred at the time, date investigation, in my opinion, d	and place, end due eath occured at the	to the cause(s) and man	ner as stated.	e) and menner ee stated.
TO BE (29b. SIGNATURE AND TITLE OF GERTIFIER	MO R	esident	^{29c} , LICENSE NUM 7788	BER	NOV	(Month, Day, Ybar) 5 1995
	30. NAME AND ADDRESS OF PERSON WHO	22 S.	M 27) (Type, Print) GREENE ST.	BALTIMORI	E,MD #2120	1	
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE					

I	TEMS:	1 - STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1 - STATE REGISTRAR CERTIFICATE OF DEATH REG. NO.	
		1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH DAY YEAR 645 NOV. 3 1995 645	O M
9		4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) # UNDER 1 YEAR # UNDER 24 HRS. 7. DATE OF BIRTH (Morith, Day, Year) 2 7 6 7 6 7 7 6 7 7 7	1/12
3 should		9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH	
2.	CTOR	LEVINDALE NURSING HOME Baltimore N/A	
nit. Pages	DIRECTOR	1 [1 1 tes 2] NO	
i. insit permit.	ERAL	2500 W.BELVEDERE AVE., APT.# 21215 U.S.A.	
215-0020 attending physician. se as the burial-transit	BY FUN	3 M Wildowed 4 □ Divorced IF YES, GIVE WAR OR DATES 1 □ YES 2 NO Specify: WHITE	
21215 al or attend for use as		15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working	
AND 21 he hospital or detached for u	ONCE.	Elementary/Secondary (9-12) College (1-4 or 8-) /// /// /// /// // /// // /// // // //	
YLA by the be del	111 B	MEYER EISNER MARTHA UNKNOWN	
	2	190. INFORMANT'S NAME (Type/Print) DR.ALLEN J.EISNER 190. MANOR HILL RD., BALTO., MD. 21208	
ORE 6 may ctor, pa	20 19 m	20a. METHOD OF DISPOSITION 1 % Burlel 2 Cremetion 3 Removal from State 4 Donetion 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 11/5/95 DATE Cemetery, crematory or other piece) LUBAWITZ NUSACH ARI (NER TAMID) 20c. LOCATION — City or Town, State ROSEDALE, MD.	
ALTIMO death. Page 6 funeral directo	ахашшаха	22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC.	
9 7		6010 REISTERSTOWN RD., BALTO, MD. 21215	
within 24 hours pletely filled in t	deem, the medical	23. PART inter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdisc or respiratory arrest, interval Betwook, or haert fellure. List only one cause on each line. Approximate Interval Betwook and December of Consetting in death) But to (Oh AS A CONSEQUENCE OF):	
certificate be of the physician Hygiene prior to	ERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): HYPERTENSIVE CARDIOVASCULAR DISEASE DUE TO (OR AS A CONSEQUENCE OF): d.	
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O THE H	BE	290. SIGNATURE AND TITLE OF CENTIFIER 3 CO. LICENSE NUMBER 29d. DATE SIGNED (Month, Day New)	
TO THE MOSPIN TO THE FUNER DE filed within	TO BE C	290. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (MONTH, Day OF LICENSE NUMBER) 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print) (1) UNITED B. OHELD M. C. T. T. PARK HELLER SIGNED (MONTH), Day OF LICENSE NUMBER 29d. DATE SIGNED (MONTH, Day OF LICENSE NUMBER)	

Serve.

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DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 25 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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	1 - FOR STATE REGISTRAR	STATE OF MARYLAND / DEPA CERTI	RTMENT OF HEALTH AND FICATE OF DEATH	MENTAL HYGIENE REG. NO.	
	1. OECEDENT'S NAME (First, Middle, Last)	J. E.	C 00-	2. DATE OF DEATH MONTH DAY	YEAR 3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER	5. SEX 8. AGE (in yrs. last birthday	EOGE () IF UNDER 1 YEAR IF UNDER 24 HRS.	7. DATE OF BIRTH	8. BIRTHPLACE (State or Foreign
	374-48-3731	1 M 2 D F 49 YRS.	MONTHS DAVE MOURS MAN	(Month, Day, Year) 1941	MICHIGAN
-	9a. FACILITY NAME (if not institution, give stre	et and number)	9b. CITY, TOWN OR LOCATION OF	DEATH 9c. COUN	TY OF DEATH
DIRECTOR	RESIDENCE OF DECEDENT	1, GEN:	COLUMBIA	Au	WARD
J. J.	10e. STATE 10b. COUNTY	10c. C	ITY, TOWN OR LOCATION		10d. INSIDE CITY LIMITS?
	MD, FIUV	VARD	DHIMBIA		1 TYES 2 THO
FUNERAL	100. STREET AND NUMBER	Marin Trung	180 E 2104	10g. CITIZ	EN OF WHAT COUNTRY?
NS C	11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 PNO	13. WAS DECENDENT OF HISP	ANIC ORIGIN? (Specify Yes or No	14. RACE — American Indian,
BY F	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 YES 2 PRO	If yes, specify Cuban, Mexi- 1 TYES 2 7 10 Specific	can, Puarto Rican, atc.)	Specific A A
	15. OECEDENT'S EQUCA	TION 16a DECEDENT	'S USUAL OCCUPATION	16b. KIND OF BUSINESS/INDI	BARC
ETED	(Specify only highest grade co		f work done during most of working	GO 1/	DSTRY
COMPL		6 AGGISTA	N VICE- PRESID	ENT DANK	
	17. FATHER'S NAME (First, Middle, Last)	1=7/5	16. MOTHER'S N	AME (First, Middle, Majden Surragie)	,
BE	19a, INFORMANT'S NAME (Type/Print)	19b. MAILIP	O ADDRESS (Street and Number or Rura	I Route Number, City or Town, State, Zio	Code) 4647 77
2	DUANE ELL	5DGE 125	08 N.E. 148TI	45T, Warmain 1	15 WASH,
	20g. METHOD OF DISPOSITION 1 D Burlat 2 Cremation 3 Remove	at from State 20b PLACE AND DAT	EOF DISPOSITION (Name of other back)	OATE 20c. LOCATION - C	City or Town, State
	4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICEY		22 MARE AND APPRIESS MICH	119195 KM 7AZ	LATOWN INV.
3	May Ny	1/2	CARY	ATTEN HUMBRA!	AUMB LIA
	23. PART/1 Enter the diseases, or co	mplications that caused the death. Do	not anter the mode of dying an	11-10n/ (195)	7,MD,21229
	ahock, pr heart failure. Lie	at only one cause on each line.	not allow the mode of dying, an	on as cardiac or respiratory sire	Approximata interval Batween Onset and Desth
	disease of condition resulting in death)	ACUTO CARDIOD	whovery Ark	34	Sulation
		DUE TO (OR AS A CONSEQUENCE OUE TO (OR AS A CONSEQUENCE OUE TO (OR AS A CONSEQUENCE	OF):		14
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E	that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEQUENCE	OF):		
E E	d.				
¥	PART II. Other significant conditions	contributing to death but not resulting	in the underlying cause given in	Part I. 24s. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO
MEDIC				1 U YES 2 NO	COMPLETION OF CAUSE OF DEATH?
	DID TOBACCO USE CONTRI	BUTE TO CAUSE OF DEATH Y	ES NO UNCERTA	IN 421	1 TES 2 NO
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	27. MANNER OF DEATH S Natural 5 Pending	28a. DATE OF INJURY (Month, Day, Year) 26b. TI	IJURY WORK?	26d. DESCRIBE HOW INJURY OCC	URED
BÝ	2 Accident Investigation	26a. PLACE OF INJURY At home, farm	M 1 YES 2 NO	281. LOCATION (Street and Number of	Per Print Posts Number
	4 Homicide 6 Could not be datarmined	building, atc. (Specify)	, occos, radio y, orrow	City or Town, State)	r nutti noole (sumos),
COMPLETED	29a. CERTIFIER 1 CERTIFYING PHYSICIA	AN: To the best of my knowledge, death occur	rred at the time, data and placa, and du	e to the cause(e) and menner as state	d.
OM	one) 2 MEDICAL EXAMINER:	On the basis of examination and/or investigat	ion, in my opinion, death occured at th	e time, data and place, end due to the	cause(a) and menner as stated.
BE 0	206. SIGNATURE AND TITLE OF CERTIFIER		29c. LICENSE NU		SIGNED (Month, Day, Year)
2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF OFATH (ITEM OT) (X-	022	2856	Venber 3, 1995
	VEGET En L Frints		THE SATURANT	At Columb	ovenbar 3, 1995 a, Mr 21044
	NOV 0 8 1995	32 REGISTRAR'S SIGNATURE	· / Le / · Late my	0/	- LIUTT
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Alberta Comment

use as the burial-transit permit. Pages 1, 2, 3 should retained by the hospital or attending physician. be detached for at page 5 should notified ofter death. Page 6 may be 99 funeral director, examiner filled in by the filon, or removal, medicai hours the cremation npletely 1 within event, and comp o burial, c executed traumatic 2 the attending physician Mental Hygiene prior to HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be other 0 Injury. s been signed by th any shows ?

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MARYLAND 21215-0020

BALTIMORE.

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DIVISION OF VITAL

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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - STATE REGISTRAR CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF CEATH 3. TIME OF DEATH YEAR RAOUEL TANEA FRANKLIN NOVEMBER 1995 4:15PM 05 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign SEPT. 18, 1995 none BALTIMORE, MD 1 M 2 XX 8Te YRS. 9a, FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF GEATH 9c. COUNTY OF OFATH UNIVERSITY HOSPITAL BALTIMORE CITY DIRECTOR RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c CITY TOWN OR LOCATION 10d. INSIDE CITY n/a MARYL AND *bALTIMORE* X YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 840 N. CAREY STREET 21217 UNITED STATES 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 YOU IF YES, GIVE WAR OR DATES 14, RACE — American Indian, Black, White, atc. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-It yes, specify Cuben, Mexican, Puarto Rican, atc.)

1 ☐ YES X X NO Specify: 1 X Never Married 2 Married Specify: BLACK BY 3 Widowed 4 Divorced COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. OFCEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Spe Elementary/Secondary (0-12) College (1-4 or 5+) BABY none n/a 18. MOTHER'S NAME (First, Middle, Maiden Surname) 17. FATHER'S NAME (First, Middle, Last) RICHARD FRANKLIN CYNTHIA KNOX BE 19a. INFORMANT'S NAME (Type/Print) 2 KAREN KNOX 840 N. CAREY STREET, BALTIMORE, MD 21217 20a, METHOD OF DISPOSITION

1 Sarial 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State ZION CEMETERY 4 Donetion 5 Other (Specify) 11 - 10LANSDOWNE. MD 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY WM. C. MARCH FH.-1101 E. NORTH **AVENUE** 23. PART . Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata Interval Between shock, or heart failure. List only one cause on each line **Onset and Death** IMMEDIATE CAUSE (Final disease or condition reaulting in death) NEAR SUDDEN INFANT DEATH SYNDROME DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other aignificant conditions contributing to death but not requiting in the underlying cause given in Pert I. 24s. WAS AN AUTOPSY MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 □ NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☑ UNCERTAIN ☐ PHYSICIAN: 28. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL **EXAMINER?** HOSPITAL:
1 Monpetient 2 ER/Outpetient 3 DOA OTHER: 1 X YES 2 - NO 4 Nursing Home 5 Residence 8 Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d, DESCRIBE HOW INJURY OCCURED 1XX Natural 5 Pending 1 YES 2 NO BY 2 Accident 261, LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicida 28a. PLACE OF INJURY — At home, term, street, tactory, office hullding, etc. (Specific) 6 Could not be COMPLETED 4 Homicide 29a. CERTIFIER

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and menner as stated. 2 TMEDICAL EXAMINER: On the besis of exemination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and menner as stated. 29th SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d, DATE SIGNED (Month, Day, Year) BE NOVEMBER 06, 1995 O.C.M.E 2 Name and Address of Person who completed cause of Death (ITEM 27) (Type, Print)

HALLY REP A. KOR ELW 111 Penn Street, Baltimore, Maryland 21201 MANY N 8 1995 MOV O

NAME OF THE PARTY.

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1. DECEDENT'S NAME (First, Middle, Last) Stephen 4. SOCAL SECURITY NUMBER		V=1	ICATE OF	ULAIII	REG. N	O.		
4. SOCIAL SECURITY NUMBER					2. DATE OF DEATH	DAY		E OF DEATH
	For				Month		YEAR 1:	36 A M
240-72-3954	17₺ M 2 🗆 F 5	(In yrs. lest birthday) O YRS.	IF UNDER 1 YEAR MONTHS DAYS	7	7. DATE OF BIRTH	45	Country)	(State or Foreign
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1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	(NJ	M 1	YES 2 NO				
3 Suicide 6 Could not be determined	building, etc. (Spe	city)	street, tectory, offi	ica	281. LOCATION (Stree City or Town, Stel	t and Number or	Rural Route Nur	nber,
								Inner as stated.
296. SIGNATURE AND TITLE OF CERTIFIER P. TryWithm	۸.			89261	ABER			
				neral HX	spital			
	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced Specify only highest grade	716 Dolphin Street 11. MARITAL STATUS 1	7.16 Dolphin Street 11. MARITAL STATUS 1	716 Dolphin Street 11. MANITAL STATUS 1 Never Merried 2 Married 12. WAS DECEDENT EVER IN U.S. ADMED PORCES? 1 YES 2 Mon 13. DECEDENT'S USUAL COCUPA (Specify only highest grade completed) 14. Never Merried 2 Married 15. DECEDENT'S USUAL COCUPA (Specify only highest grade completed) 16. DECEDENT'S USUAL COCUPA (Give Mail of work down during if 18. DECEDENT'S USUAL COCUPA (Give Mail of work down during if 18. DECEDENT'S USUAL COCUPA (Give Mail of work down during if 18. DECEDENT'S USUAL COCUPA (Give Mail of work down during if 18. DECEDENT'S USUAL COCUPA (Give Mail of work down during if 18. DECEDENT'S USUAL COCUPA (Give Mail of work down during if 18. DECEDENT'S USUAL COCUPA (Give Mail of work down during if 18. DECEDENT'S USUAL COCUPA (Give Mail of work down during if 18. DECEDENT'S USUAL COCUPA (Give Mail of work down during if 18. DECEDENT'S USUAL COCUPA (Give Mail of work down during if 18. DECEDENT'S USUAL COCUPA (Give Mail of work down during if 18. DECEDENT'S USUAL COCUPA (Give Mail of work down during if 18. DECEDENT'S USUAL COCUPA (Give Mail of work down during if 18. DECEDENT'S USUAL COCUPA (Give Mail of work down during if 18. DECEDENT'S USUAL COCUPA (Give Mail of work down during if 18. DECEDENT'S USUAL COCUPA (Give Mail of work down during if 18. DECEDENT'S USUAL COCUPA (Give Mail of work down during if 18. DECEDENT'S USUAL COCUPA (Give Mail of work during if 18. DECEDENT'S USUAL COCUPA (Give Mail of wire during if 18. DECEDENT'S USUAL COCUPA (Give Mail of work during if 18. DECEDENT'S USUAL COCUPA (Give Mail of wire during if 18. DECEDENT'S USUAL COCUPA (Give Mail of wire during if 19. DECEDENT'S USUAL COCUPA (Give Mail of work during if 19. DECEDENT (Give Mail of wire during if 19. DECEDENT (Give Mail of wire during if 19. DECEDENT (Give Mail of the death of work during if 19. DECEDENT (Give Mail of the death of work during if 19. DECEDENT (Give Mail of the death of work during if 19. DECEDENT (Give Mail of the death of work during if 19. DECEDENT (Gi	7.16 Dolphin Street 21217 11. WARNTAL STATUS 1 New Married 2 Married 3 Process 1 Yes 2 Process 1 Yes 3 Process 2 Yes 2 Process 3 Yes 2 Process 3 Yes 3 Process 4 Yes 3 Yes 3	7.16 Dolphin Street 11. MARTAL STATUS 11. Marthal 2 Married 21. Marthal 2 Married 21. Marthal 2 Married 22. Marthal 2 Married 23. Windowed of Divorced 11. DECEOENT'S EUROLA COCCIPATION [Speedly only highest accol complication [Speedly only highest accol complex acc	7.16 Dolphin Street 11. MANKEN STATUS 12. WAS DOCCEDENT FUER NU.S. AMMED 13. WAS DOCCEDENT OF HERDANC CHICARY (Specify) Yes or No- 14. Never Married 15. Note That Price of the Control of the Contr	The Dolphin Street 12. WAS DECIDENT STATUS 13. WAS DECIDENT STATUS 13. WAS DECIDENT STATUS 14. WAS DECIDENT STATUS 15. WAS DECIDENT STATUS 16. WAS DECIDENT STATUS 17. WAS DECIDENT STATUS 18. RECEDENT STATUS 18. RECEDENT STATUS 19. WAS DECIDENT STATUS 19. WAS DECIDENT STATUS 10. DECEDENT STATUS 10. WAS DECIDENT STATUS 10. WAS DECID

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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MARYLANI		TMENT OF H		MENTAL	HYGIENI REG. NO.	Ē		
	1. DECEDENT'S NAME (First, Middle, Lest) FRANK	В.		GNAC	νV	2. DATE OF	F DEATH	2,19	3.	TIME OF DEATH 3:10 P.M
			s. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7 DATE OF	BIRTH	0.1	DIRTHPL/	CE (State or Foreign
		X M 2 □ F 69	YRS.	MONTHS DAYS	HOURS MIN.	July	26, 1	1926	- 46	land
OR	9a. FACILITY NAME (If not institution, give stree 2745 WEGWORTH LA				MORE CI			9c. COUNTY N/A	OF DEAT	н
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		10c. CITY	, TOWN OR LOCAT	ION				10	d. INSIDE CITY
PIB	Maryland N/A		Ba	ltimore						LIMITS?
FUNERAL	2745 Wegworth La	ne		101	21230			10g. CITIZEN	OF WHA	T COUNTRY?
S		2. WAS DECEDENT EVER IN U.S FORCES? 1 X YES 2	S. ARMED		ENDENT OF HISPAI			or No- 14.		American Indian, hita, atc.
ВУ	1 Never Married 2 X Married 3 Wildowed 4 Divorced	IF YES, GIVE WAR OR DATES	3		2 X NO Specif		an, atc.)		Specify:	
	15. DECEDENT'S EDUCAT	World War	. DECEDENT'S	USUAL OCCUPATION	ON	16b. K	IND OF BUS	INESS/INDUST	RY	White
COMPLETED	(Specify only highest grade con Elementary/Secondary (0-12)	mpleted) College (1-4 or 5+)	(Give kind of w life. Do NOT use	ork done during mo e retired.)	st of working					
MPL	10th		Genera	1 Worke	•	7	ransf	ormer	Com	pany
8	17. FATHER'S NAME (First, Middle, Last)	rtin Gnacyk			18. MOTHER'S NA	- 11 - 12 - 12 - 12	idle, Malden	Sumame)		
BE		TUIN GHACYK					Kons			
2	19a. INFORMANT'S NAME (Type/Print) Cecelia Gnacyk			ADDRESS (Street a Vegworth	nd Number or Rural					21220
. 1	20a. METHOD OF DISPOSITION	I ans as		FDISPOSITION (Na		DATE		ATION - City		21230
	1 X Burlai 2 Cremation 3 Ramove 4 Donation 5 Other (Specify)	of from State	y, crematory or other	her placa) Veterar	s Cem.	11/6				Maryland
	21. SIGNATURE OF FUNERAL SERVICE LICEN	ISEE	r	22. NAME AN	D ADDRESS OF FA	CILITY				
	· Juone gran	newyll		_	e J. Gon					
	23. RART I. Enter the diseases, or cor		e daeth. Do n		Ritchie					Z1ZZ5
	ahock, Dr haart fallure. Lis IMMEDIATE CAUSE (Final	it Dnly one cause on each	fine.							Interval Between Onset and Death
	44	Arterioscle	erotic	Cardi	ovascul	ar D	iseas	se		
	readiting in deality . a	DUE TO (OR AS A CO								
Z	Sequentially list conditions, b.									
E I	if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A CO	NSEQUENCE OF	j:						
FIC	CAUSE (Disease Dr Injury that initiated events	DUE TO (DR AS A CO	NSEQUENCE DE							
CERTIFICATION	resulting in death) LAST			•						
				- Ab Ai ab b		2				
SAL	PART II. Other algorificant conditions	contributing to beath but r	not rasulting i	n the underlying	g cause given in	ł	PERFOR	MED?	AV	ERE AUTOPSY FINDINGS AILABLE PRIOR TO IMPLETION OF CAUSE
Ē						- 1	USPE(CTION	OF	DEATH?
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SIC		IOSPITAL:	nt 3 🗆 DOA	OTHER:	e 5 X Residenca	8 Other	Specify)			
Ή	27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIMI	E OF 28c. INJ	- 21	T		NJURY OCCUR	ED	
ВУР	1 Natural 5 Pending 2 Accident Investigation	(WOMI, Day, Ibal)	143		YES 2 NO					
EDE	3 Suicide 8 Could not be	28a. PLACE OF INJURY — / building, atc. (Specify)	At home, farm, a	treat, factory, offic	•		ION (Street a Town, State)	nd Number or I	Rurel Roul	e Number,
COMPLET	and an only	N: To the best of my knowledg On the terms of minimum an							iuse(s) ai	nd manner as stated.
BE C	THE BIGHATURE AND TITLE OF CERTIFIER	that I	-		29c, LICENSE NU	MBER		29d. DATE SI	GNED (M	onth, Day, Year)
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	NOV 0 8 1995	32 REGISTRAR'S SENATU								
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last)
HELEN L. GROFF 2. DATE OF DEATH 3. TIME OF DEATH NOVEMBER 03 10:10 PM 1995 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In vrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign May 3, 1919 224-14-6664 76 VIRGINIA 1 - M 2 - XF HOURS 9a. FACILITY NAME (If not institution, give street and number)
BAY VIEW MEDICAL CENTER 9c. COUNTY OF DEATH 96. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY N/A RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION DUNDALK MARYLAND BALTIMORE 10d. INSIDE CITY 1 YES 2 XNO 101. ZIP CODE 21222 10- STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? 101 CENTER PLACE U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 ANO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indien, Black, White, etc. 1 Never Married 2 Married If yea, specify Cuban, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify: Specify WHITE 3 📉 Widowed 4 🗌 Divorced 15. DECEDENT'S EDUCATION 18e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working 186. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) 8 yrs College (1-4 or 5+) TEXTILE WORKER COTTON MILL 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) JOHN T. GILLISPIE MATTIE DIAMONT 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3402 YARDLEY DRIVE , BALTIMORE, MD 21222 19a. INFORMANT'S NAME (Type/Print) MR. EDMOND GROFF 20a. METHOD OF DISPOSITION
1 Burlet 245 Cremetion 3 Ramoval from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State CHESAPEAKE CREMATORY, INC.11/5/95 BELTSVILLE, MD 4 Onnellon 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE BRADLEY ASHTON FUNERAL HOME, INC. 2134 WILLOW SPRING RD. DUNDALK, MD 21222 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardisc or respiratory strest, ahock, or heart feilure. List only one ceuse on each line **Onset and Death** IMMEDIATE CAUSE (Final disease or condition HYPOXIA 2 days reaulting in death) DUE TO (OR AS A CONSEQUENCE OF): CHRONIC OBSTRUCTIVE PULMONARY DISEASE many years Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING ALPHA-I-ANTIPRYPSIN DEFICIENCY many years CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events reaulting in death) LAST PART II. Other aignificant conditions contributing to deeth but not resulting in the underlying ceuse given in Part i. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? PNEUMOTHORAX, CORONARY ARTERY DISEASE 1 YES 2 NO OF DEATH? CORONARY HEART PAILURE 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES 🗵 NO 🗌 UNCERTAIN 🗆 PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one HOSPITAL:
1 N Inpetient 2 ER/Outpetient 3 DOA OTHER: 1 TYES 2 NO 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 X Natural 1 YES 2 NO 2 Accident 28e. PLACE OF INJURY — Al home, ferm, street, factory, office building, atc. (Specify) 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 4 Homicide 29s. CERTIFIER (Check only 1 🖔 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(e) and menner as stated. 29b, SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIONED (Month, Day, Year) 29c. LICENSE NUMBER Carolyn Howk M.D. 96008

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print) EW Medical Center
Carolyn Howk M.D. Johns Hopkins Bay view Medical Center ► November 3, 1995

4940 Eastern Nenre Baltimore, no 21224 Pages 1, 2, 3 should

permit. the burial-transit 24 hours after death. Page 6 may be retained by the hospital or attending physician. ŏ page 5 should be detached once. notified at pe must funeral director, examiner the medical filled in by 0 cremation, traumatic event, the completely bunal, executed and prior to physician HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be other t the attending phys 1 Mental Hygiene p 6 and a any Signed t shows certificate has been h the State Dept. of h 23 Hem 0 marked, this c DIRECTOR: After the hours after death 89 28 Item ? TO THE FUNERAL DE filed within 72 h 223

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95 33552 Items10b,c,e&f,g-729,11-8-95,perf,h.,dk FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 45 JLENN 11 05 1022 AM TAVER 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In vrs. lest birthdev) 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 1 YEAR IF UNDER 24 HRS. S. BIRTHPLACE (State or Foreign 216464096 1 M 2 F HOURS 13 MARYLAND 9e. FACILITY NAME (If not institution, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR STMINSTER ARROLL RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY TOWN OR LOCATION 19d. INSIDE CITY LIMITS? Baltimore Spanks EAD 000 1 YES 2-10HO FUNERAL 10s. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? 704 Indian Spring Court 21152 .SA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-14. RACE — American Indian, Black. White, etc. If yes, specify Cuben, Mexican, Puerto Ri

1 YES 2 NO Specify: FORCES? 1 YES 1 M Never Married 2 Merried YES, GIVE WAR OR DATES BY 3 Widowed 4 Divorced HITZ 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade comp ive kind of work done Do NOT use retired.) COMPLET Elementary/Secondary (0-12) College (1-4 or 5 +) N/A 5 UNEMPLOYEED 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First Middle Meiden Surname OSCAR GAVER, SR. FRANKLIN ZONA Κ. VIRTS 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 INDIAN SPRING COURT, 21152 MR. OSCAR F. GAVER. SPARKS, MD 20e. METHOD OF DISPOSITION
1 □ Burlal 2 X Cremation 3 □ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State 4 Donation 5 Other (Specify) CHESAPEAKE CREMATORY BELTSVILLE, MARYLAND 21. SIGNATURE-OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY BRADLEY-ASHTON FUNERAL HOME, 2134 WILLOW SPRING RD. BALT.

23. PART I. Enter the **sesses, or complications that caused the desth. Do not enter the mode of dying, such as cardiac or respiratory street, shock, or haart failure. List only one cause on each line. BRADLEY-ASHTON FUNERAL HOME, INC. 2134 WILLOW SPRING RD. BALT., 21222 intervsi Between Onset and Death **IMMEDIATE CAUSE (Final** disease or condition_ 30mir arre5 ardiac resulting in death) DUE TO (OR AS A CONSEQUENCE OF 09 CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Entar UNDERLYING DUE TO (OR AS A CONSEQUENCE OF): CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS PHYSICIAN: MEDICAL AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES INO DUNCERTAIN I 26. PLACE OF DEATH (Check only one, 25. WAS CASE REFERRED TO MEDICAL 1 TES 2 NO Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending Investigation 1 YES BY Accident 28e. PLACE OF INJURY — At home, term, street, tectory, office building, etc. (Specify) 3 Suicide 28t. LOCATION (Street end Number or Rural Route Number, City or Town, State) ETED 8 Could not be 4 Homicide 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(e) and menner as stated. COMPL MEDICAL EXAMINER: On the besis of examination end/or investigation, in my opinion, death occured at the time, date and piece, and due to the cause(e) and manner se stated.

29d. DATE SIGNED (Month, Day,

296. SIGNATURE AND TITLE OF CENTIFIER 29c. LICENSE NUMBER D ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

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32. RE MISTRARE SIGNATURE ROMAN 31. DATE FILED /A

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hosp	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached		IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 CERTIFICATE OF DEATH REG NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATN 3. TIME OF DEATH Nov 7 1995 3:25 am OTHO ANTHONY **GUGLIOTTA** 7. DATE OF BIRTN
(Month, Day, Year)
Dec. 26,1926 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign DAYS 216-20-4169 1X M 2 | F Maryland Se. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Baltimore Saint Joseph Medical Center Towson, Maryland RESIDENCE OF DECEDENT 10c. CITY. TOWN OR LOCATION 10d. INSIDE CITY Maryland Baltimore Rosedale 1 YES 2 NO 10e. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 1205 Roxboro Road 21237 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2
IF YES, GIVE WAR OR DATES If yes, specify Cuben, Mexican, Puerto Rican, etc.)

1 YES 2 Y NO Specify: 1 Never Married 2 Married 2 NO White 3 Widowed 4 Divorced 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5 +) Ship Docking Pilot Shipping 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname) Frank Gugliotta Helen Heaps 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Kevin A. Gugliotta 42 Glen Alpine Road Phoenix, Maryland 21131 20s. METHOD OF DISPOSITION 20c. LOCATION - City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 1 X Burial 2 Cremation 3 Removal from State
4 Donetion 5 Other (Specify) Gardens of Faith Cem. Baltimore Maryland 11/10/95 21. SIGNATURE OF EMPERAL SERVICE LICE 22. NAME AND ADDRESS OF FACILITY Kokwel Leonard J. Ruck, Inc. 5305 Harford Road 21214 23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, Approximata Interval Between shock, or heert fallure. Liet only one cause on each line. Onset and Death IMMEDIATE CAUSE (Final disease or condition CARDIORESPIRATORY FAILURE resulting in death) DUE TO (OR AS A CONSEQUENCE OF): CONGESTIVE HEART FAILURE Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) If any, leading to immediate cause. Enter UNDERLYING CARDIOMEGALY CAUSE (Disesse or Injury DUE TO (OR AS A CONSEQUENCE OF): thet initiated events resulting in deeth) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part i. 24a, WAS AN AUTOPSY PERFORMED? AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 | YES 2 | N OF DEATH? 1 TES 2 N DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO INCERTAIN 26. PLACE OF DEATN (Check only one 25. WAS CASE REFERRED TO MEDICAL HOSPITAL:
1 | Injection: 2 | ER/Outpetient 3 | DOA OTHER: 1 YES 2 NO 27. MANNER OF DEATN 26e. DATE OF INJURY (Month, Day, Year) 26b. TIME OF INJURY 26c. INJURY AT WORK? 28d. DESCRIBE NOW INJURY OCCURED 1 Natural
2 Accident 5 Pending 1 YES 2 NO Investigation 26s. PLACE OF INJURY — At home, farm, street, fectory, office building, stc. (Specify) 3 Suicide 26f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 1 CONFINE PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the peaks of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND THE OF 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 11/7/95 D44997 THE AND ADDRESS OF PURSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

RENE ALVAREZ, MD 7620 YORK ROAD TOWSON, MARYLAND 21204

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30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Dr. Tahir Sajjad

31. DATE FILED MOV 0 0 8 1995

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Item#1. G-film 729 per F.H 11/08/95 P.C FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH DELORES A. HERR 6:00 AM Dolores Herr NOVEMBER 5, 1995 Α. B. BIRTNPLACE (State or Foreign Country) 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Dev. Year) IF UNDER 1 YEAR IF UNDER 24 HRS. DAYS HOURS 219 22 9389 1 M 2 XF 66 Feb. 1, 1929 Maryland 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH Se COUNTY OF BEATN BURNIE NORTH ARUNDEL HOSP GLEN ARUNDEL ANNE FUNERAL DIRECTOR RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Anne Arundel Riviera Beach 1 TYES 2 NO 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 8543 Main Avenue 21122 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 THO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married If yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 TYES 2 NO Specify: Specify: BY 3 Widowed 4 Divorced White 16e. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade comp (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) Map Clerk State of Maryland 12th 17. FATNER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Joseph Herr Helen V. Martel BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Joseph H. Herr 8543 Main Avenue Riviera Beach, Maryland 21122 20s. METNOD OF DISPOSITION
1 To Burisl 2 Cremetion 3 Removal from State
4 Donetion 6 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE Holy Cross Cemetery 11/8 Baltimore, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY George J. Gonce Funeral Home P.A. 23. PART I. Enter the diseases, or complications that coused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart collure. List only one couse on each line. 4001 Ritchie Hwy. Baltimore, Md. 21225 Approximate Interval Batween Onset and Death IMMEDIATE CAUSE (Finel disease or condition KESPIRATORY FAILURE reauiting in deeth) DUE TO (OR AS A CONSEQUENCE OF): EDEMA AC UTE PULMONARY PHYSICIAN: MEDICAL CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury RENAL FAILURE DUE TO (OR AS A CONSEQUENCE OF): that initiated events YPERTENSION resulting in deeth) LAST PART II. Other aignificent conditions contributing to deeth but not resulting in the underlying ceuse given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE DIABETES MELLITUS. BRONCHIAL ASTHMA. 1 TES 2 NO OF DEATH? 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO W UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATN (Check only one) HOSPITAL: 1 YES 2 1 NO 1 K Inpatient 2 - ER/Outpetient 3 - DOA 28a. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28c. INJURY AT WORK? 28b, TIME OF 28d, DESCRIBE HOW INJURY OCCURED INJURY 1 X Natural 5 Pending 1 YES 2 NO BY 2 Accident Investigation TO THE HOSPITAL OR ATTENDING TO THE FUNERAL DIRECTOR: After be filed within 72 hours after deat IMPORTANT: If Item 28 is m 3 Suicide 28s. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined COMPLETED 4 Nomicide 29e. CERTIFIER (Check only one)

One)

MEDICAL EVAMINED: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29d. DATE SIGNED (Month, Day, Year)

NOVEMBER 5,95 29b. SIGNATURE AND TITLE OF CERTIFIER John Sayard House Physician NAH. 29c. LICENSE NUMBER

303 Hospital Drive

32 MORE TO WESTERNAMEN CONSOLL

D46779

Glen Burnie, Maryland 21061

DHMH-16 Rev 1/86

filled in by the funeral director, page 5 should be detached for use as the burial-transit permit, Pages 1, 2, 3 should ngurs after death. Page 6 may be retained by the hospital or attending physician. been signed by the attending physician and completely filled in α , of Health and Mental Hygiene prior to burial, cremation, or tOR ATTENDING PHYSICIAN; The law requires that the death certificate be executed with Dept. has DIRECTOR; After this certificate I hours after death with the State item 28 TO THE HOSPITAL.
TO THE FUNERAL I
be filed within 72 h
IMPORTANT. II II HOSPITAL

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1 Natural

2 Accident

3 Suicide

4 Homicide

PHYSICIAN: MEDICAL CERTIFICATION

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG. NO. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME DE DEATH owarc Am 0 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIFTTN (Month), Day, Year IF UNDER 24 HRS. 8. BIRTNPLACE (State or Foreign -80 1 X M 2 - F 3 01/01 9a. FACILITY NAME (If not institution, give street NOR LOCATION OF DEATH Ba BY FUNERAL DIRECTOR MULLING 1 more DECEDENT 10a. STATE TY, TOWN DR LOCATION 10d. INSIDE CITY MORE 1 - VES 2 | NO STREET AND NUMBE 10f. ZIP CODE 10g. CITIZEN OF 10 o 12. WAS DECEDENT EVER IN U.S. ARMED 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2 ND 1 Never Married 2 Married IF YES, GIVE WAR DR DATES Black Specify: 3 Widowed 4 Divorced BE COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY College (1-4 or 5+) 17. FATHER'S NAME (First, Middle Last 16. MOTNER'S NAME (First, Middle, Maiden 0 METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (7 2 Cremation Donation 5 - Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or reepiratory arreat, ahock, or haert failure. List only one Interval Batwe IMMEDIATE CAUSE (Final Onset and Death disease or condition uman mmunode Lyean resulting in death) DUE TO (OR AS A CONSEQUENCE OF) Sequentieity ilst conditions. DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE DF): that initiated events resulting in death) LAST

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN

PART II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 TYES 2 NO

HOSTICE

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 NO

25. WAS CASE REFERRED TO MEDICAL	26. PLACE OF DEATN (Check only one)									
1 YES 2 NO	HOSPITAL: 1 Inpatient 2 ER/Outpatient 3	DOA 4 NAV	R: rsing Home 5 - Residence	6 🗆						
27. MANNER OF DEATH	28a DATE OF IN HIRV	ORL THEF OF	00 - MI HIERY AT	Lan						

28a. DATE OF INJURY (Month, Day, Year)

28c. INJURY AT WORK? 1 YES

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28d. DESCRIBE HOW INJURY OCCURED 281. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER death occurred at the time, data and place, and due to the cause(a) and manner as stated.

26s. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)

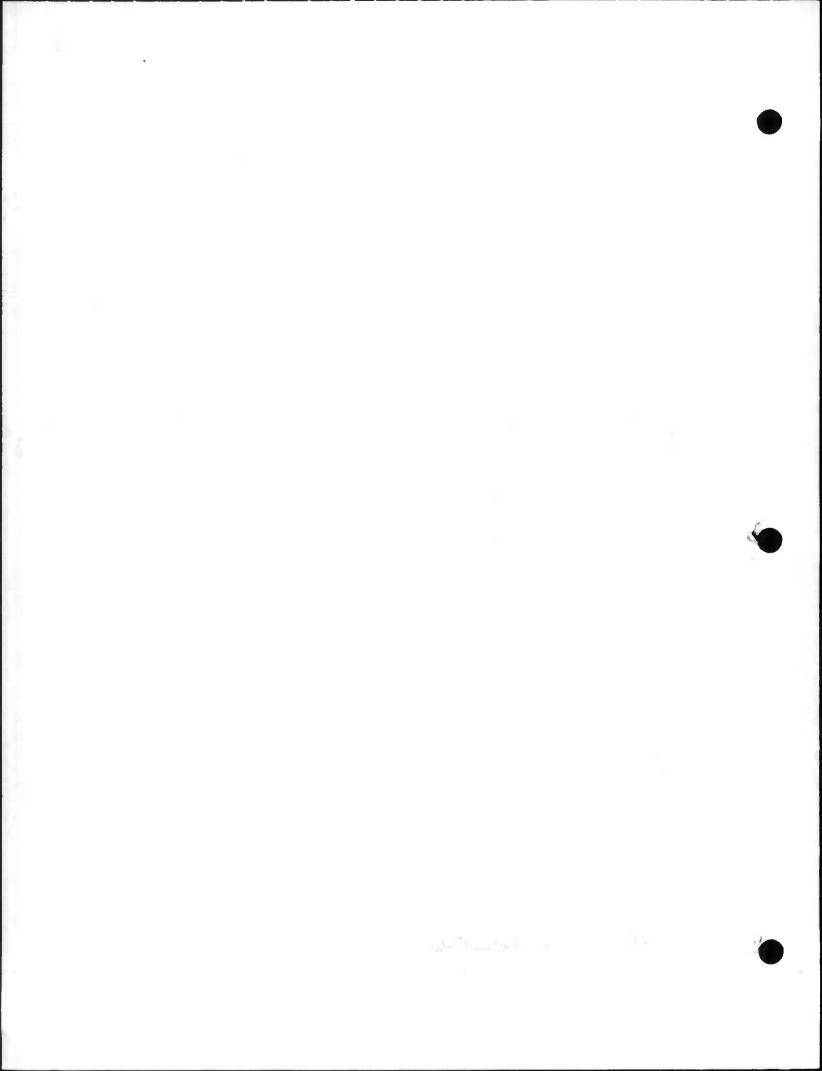
eatigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated. 29c. LICENSE NUMBER

DEATH (ITEM 27) (Type, Print)

8 1995 0

8 Could not be

DHMH-16 Rev 1/89



3. TIME OF DEATH

8:00

10d. INSIDE CITY

14. RACE — American Indian, Black, White, atc.

1 YES 2 NO

White

21093

24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?

1 YES 2 NO

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Onset and Death

BIRTHPLACE (Stete or Foreign Country)

Maryland

Baltimore

USA

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1 YES 2 X NO

27. MANNER OF DEATH

1 X Natural
2 Accident

3 Suicide

4 Homicide

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	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed w	TO THE FUNERAL DIRECTOR; After this certificate has been signed by the attending physician and comp	10	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic err
	-	1	Δ	

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH Rayner Wilson Hesse, Sr. 5. November 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year IF UNDER 1 YEAR IF UNDER 24 HRS. HOURS DAYE 216-14-7581 1 X M 2 -73 April 12,1922 Se. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF BEATH 9c. COUNTY OF DEATH DIRECTOR 10604 Topsfield Drive Cockeysville RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION Maryland Baltimore Cockeysville FUNERAL 10e. STREET AND NUMBER 10g, CITIZEN OF WHAT COUNTRY? 10604 Topsfield Drive 21030 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, OIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIOIN? (Specify Yea or No—if yes, specify Cuben, Mexican, Puerio Rican, etc.)

1 YES 2 NO Specify: 1 Never Merried 2 X Married BY 3 Widowed 4 Divorced 16e. DECEDENT'S USUAL OCCUPATION

The blad of work done during most of working COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY College (1-4 or 5+) 12 Real Estate Salesman 0i1 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surneme) John Andrew Hesse BE Florence Wilson 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 Dorothy M. Hesse 10604 Topsfield Dr., Cockeysville, MD 20s. METHOD OF DISPOSITION
10 Burlel 2 Cremetion 3 Remo
4 Donation 5 Other (Specify)
21. SIGNATOR: FUNERAL SERVICE LIGHT 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State 96 JE Sherwood Episcopal Cockeysville, MD Nov 22. NAME AND ADDRESS OF FACILITY Dulantu. Bryan W. Clary Lemmon Funeral Home 10 W. Padonia Rd., Timonium, MD diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdisc or respiratory arrest, heart failure. List only one cause on each line. 23. PART I. Enter the shock, or IMMEDIATE CAUSE (Pinal disease or condition resulting in death) Heart Failure DUE TO OR AS A CONSEQUENCE OF) Heart Disease Atherosclerotic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) If any, leading to immediate CRUSA, Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initioted avents resulting in death) LAST PART II. Other algnificent conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. MEDICAL 24a. WAS AN AUTOPSY Chronic Yenal failure 1 YES 2 NO Diabetes Mellitus DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 26. PLACE DF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL HOSPITAL:

29e. CERTIFIER
(Check only one)
2 MEDICAL EXAMINES: On the best of my knowledge, death occurred at the time, date end place, and due to the cause(e) and menner as stated. ition end/or investigation, in my opinion, death occured at the time, date and place, end due to the cause(e) end manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d, DATE SIGNED (Month, Day, Year) Haule Dual attending HA. Nov 7, 1995

28b. TIME OF INJURY

28e. PLACE OF INJURY — At home, ferm, streat, factory, office building, atc. (Specify)

4 ☐ Nursing Home 5 🎇 Residence 6 ☐ Other (Specify)

28d. DESCRIBE HOW INJURY OCCURED

281. LOCATION (Street and Number or Rural Route Number, City or Town, State)

26c. INJURY AT WORK?

1 YES 2 NO

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

investigation

8 Could not be

1 Inpetient 2 ER/Outpetient 3 DOA

26a. DATE OF INJURY (Month, Day, Year)

Warren Israel, M.D. 6569 N. Charles St., suite 600, Baltimore, MD



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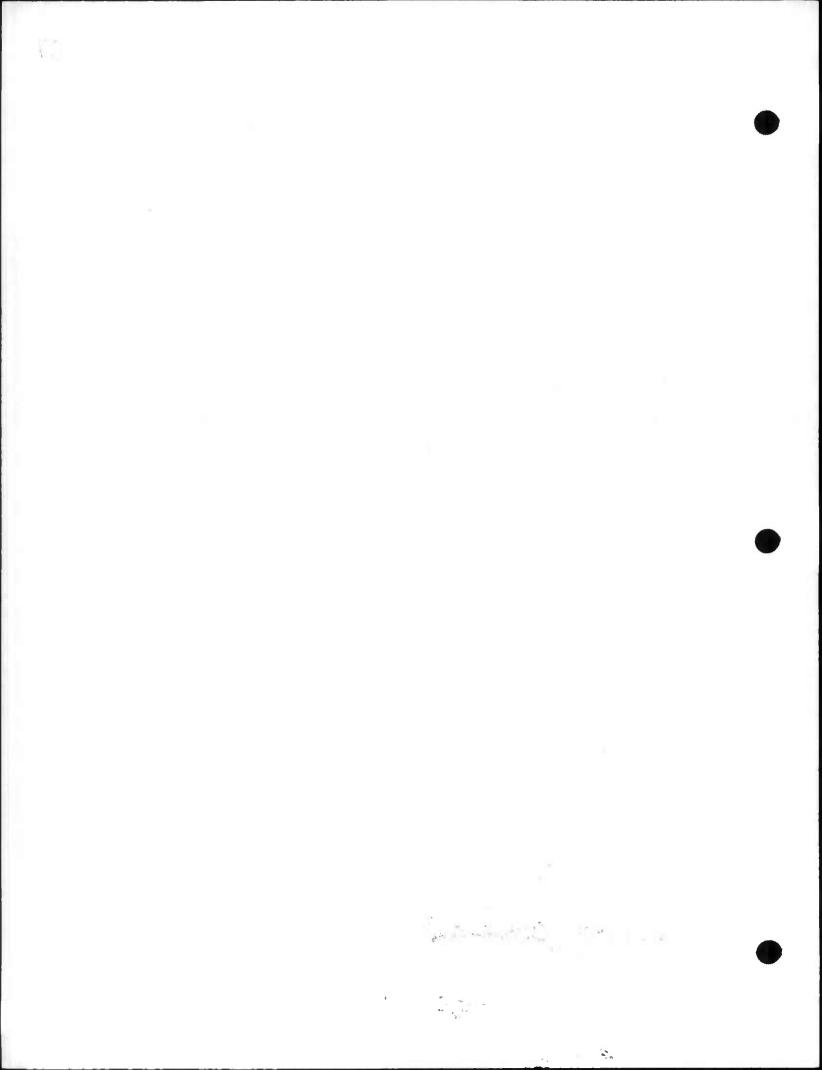
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20a. METHOD OF DISPOSITION XX Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSES 22. NAME AND ADDRESS OF FACILITY WILLIAM C. BROWN COMMUNITY F/H 1206 W. NORTH AVENUE 23. PART I. Enter the diseases, or compilications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, interval Betwoonset and Due to (OR AS A CONSEQUENCE OF): DUE TO (OR AS												9	5	33557
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AMELIA ALNETA HEBB 4. AOCAL SECURITY NUMBER 219-38-1741 10 2XXF 53 YRB. 10 AOC (IF YT) lest carringly procedure lower works are compared to the compared of the compared lower works are compared to the compared of the compared lower works are compared to the compared lower low		REGISTRAR	 	С	ERTIF	ICATE	OF	DEA	ГН	_				
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The part of the pa					at birthday)	IF UNDER	t YEAR	IF UNDER	24 HRS.	7. DATE	OF BIRTH		77.D	HPLACE (State or Foreign
BE PACITY NAME (7) not patiently only betweet and number) WERCY HOSPICE WERCY HOSPICE WERCY HOSPICE WERCY HOSPICE WERDIENDED OF DECEDENTY 100. STREET AND HUMBER 110. Pennsyl vania Avenue Apt 901 111. MARITAL STATUS 110. Deennsyl vania Avenue Apt 901 111. MARITAL STATUS 110. Deennsyl vania Avenue Apt 901 111. MARITAL STATUS 110. Deennsyl vania Avenue Apt 901 111. MARITAL STATUS 110. Deennsyl vania Avenue Apt 901 111. MARITAL STATUS 110. Deennsyl vania Avenue Apt 901 111. MARITAL STATUS 110. Deennsyl vania Avenue Apt 901 111. MARITAL STATUS 110. Deennsyl vania Avenue Apt 901 111. MARITAL STATUS 110. Deennsyl vania Avenue Apt 901 111. MARITAL STATUS 110. Deennsyl vania Avenue Apt 901 111. MARITAL STATUS 110. Deennsyl vania Avenue Apt 901 111. MARITAL STATUS 110. Deennsyl vania Avenue Apt 901 111. MARITAL STATUS 110. Deennsyl vania Avenue Apt 901 111. MARITAL STATUS 110. Deennsyl vania Avenue Apt 901 111. MARITAL STATUS 110. Deennsyl vania Avenue Apt 901 111. MARITAL STATUS 110. Deennsyl vania Avenue Apt 901 110. MARITAL STATUS 110. Deennsyl vania Avenue Apt 901 110. MARITAL STATUS 110. Deennsyl vania Avenue Apt 901 110. MARITAL STATUS 110. Deennsyl vania Avenue Apt 901 110. MARITAL STATUS 110. Deennsyl vania Avenue Apt 901 110. MARITAL STATUS 110.										18 1	942	MA	RYLAND	
19. STREET AND NUMBER 1100 Pennsylvania Avenue Apt 901 11. MANTAL STATUS 1 Nower Married 2 Married 3 Modered 4 (Motorcead 4 (Motorcead) 4	_	9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH										9c. COU	INTY OF I	DEATH
19. STREET AND NUMBER 1100 Pennsylvania Avenue Apt 901 11. MANTAL STATUS 1 Nower Married 2 Married 3 Modered 4 (Motorcead 4 (Motorcead) 4	1 PE	DITE THORE OF										N,	/A	
19. STREET AND NUMBER 1100 Pennsylvania Avenue Apt 901 11. MANTAL STATUS 1 Nower Married 2 Married 3 Modered 4 (Motorcead 4 (Motorcead) 4	EC				10c. CIT	Y, TOWN O	R LOCATI	ION						10d. INSIDE CITY
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BLACK Specify: Sp	INERAL											10g. CIT	IZEN OF	
BLACK Specify: Sp													U.S	.A.
Sementary September Sept			FORCES? 1	YES 2	RMED NO	13. 1	NAS DECI	ENDENT C	of HISPAN n, Mexica	NIC ORIGIN In, Puarto F	7 (Specify Yas lican, atc.)	or No-	14. RAC Bloc	E — American Indian, ck, Whita, atc.
15. DECEDBAT'S EDUCATION (Specify on highest groad completed) Elamentary/Secondary (9-12) 8th grade 15. MOTHER'S NAME (First, Micolin, Last) Julius Hill, Sr. 16. MOTHER'S NAME (First, Micolin, Last) Julius Hill, Sr. 16. MOTHER'S NAME (First, Micolin, Last) Julius Hill, Sr. 16. MOTHER'S NAME (First, Micolin, Last) Julius Hill, Sr. 16. MOTHER'S NAME (First, Micolin, Last) Julius Hill, Sr. 16. MAILING ADDRESS (Street and Number or Rural Poulse Number, City or Rura, State, Zip Code) Rev. Mildred Davis 20s. METHOD OF DISPOSITION XX Burster 2 Corewation 3 Removal from State 4 Donation 8 Dother (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSES 22. NAME AND ADDRESS of FLOOR XI SIGNATURE OF FUNERAL SERVICE LICENSES 23. PART I. Enter the diseases, or complications that caused the death, Do not enter the mode of dying, such as cerdisc or respiratory arrest, interval Betwo Onset and December 1 on the Interval Betwo Onset Interval Betwo		3 Widowed 4 XXOIvorced	IF YES, GIVE W	AR OR DATES		_ '	YES	2 X X NO	Specifi	y:			Spec	BLACK
JUITUS HTII, Sr. 19a. INFORMANT'S NAME (PyperPrint) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1100 Pennsy) Vania Avenue Apt 704 Baltimore. Maryl 20a. METHOD of DISPOSITION XX Burlal 2 Chemetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION [Name of OATE OTHER (Recomption)] 21. SIGNATURE OF FUNERAL SERVICE LICENSES 21. SIGNATURE OF FUNERAL SERVICE LICENSES 22. NAME AND ADDRESS OF FACILITY WILLIAM C. BROWN COMMUNITY F/H 1206 W. NORTH AVENUE 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, interval Betwoonset and December of the cause. Enter UNDERLYING Cause. Enter	8	15. DECEDENT'S EDUC (Specify only highest grade of	ATION completed)						10	16b.	KIND OF BU	SINESS/IN	DUSTRY	
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198. INFORMANT'S NAME (Type/Print) Rev. Mildred Davis 1100 Pennsylvania Avenue Apt 704 Baltimore. Maryl Rev. Mildred Davis 1100 Pennsylvania Avenue Apt 704 Baltimore. Maryl Rev. Mildred Davis 1100 Pennsylvania Avenue Apt 704 Baltimore. Maryl Rev. Mildred Davis 1100 Pennsylvania Avenue Apt 704 Baltimore. Maryl Rev. Mildred Davis 1100 Pennsylvania Avenue Apt 704 Baltimore. Maryl Rev. Mildred Davis 1100 Pennsylvania Avenue Apt 704 Baltimore. Maryl Rev. Mildred Davis 1100 Pennsylvania Avenue Apt 704 Baltimore. Maryl Rev. Mildred Davis 1100 Pennsylvania Avenue Apt 704 Baltimore. Maryl Rev. Mildred Davis 1100 Pennsylvania Avenue Apt 704 Baltimore. Maryl Rev. Mildred Davis 1100 Pennsylvania Avenue Apt 704 Baltimore. Maryl Rev. Mildred Davis 1100 Pennsylvania Avenue Apt 704 Baltimore. Maryl Rev. Mildred Davis 1100 Pennsylvania Avenue Apt 704 Baltimore. Maryl Rev. Mildred Davis 1100 Pennsylvania Avenue Apt 704 Baltimore. Maryl Rev. Mildred Davis 1100 Pennsylvania Avenue Apt 704 Baltimore. Maryl Rev. Mildred Davis 1100 Pennsylvania Avenue Apt 704 Baltimore. Maryl Rev. Mildred Davis 1100 Pennsylvania Avenue Apt 704 Baltimore. Maryl Rev. Mildred Davis 1100 Pennsylvania Avenue Apt 704 Baltimore. Maryl Rev. Mildred Davis 1100 Pennsylvania Avenue Apt 704 Baltimore. Maryl Rev. Mildred Davis 1100 Pennsylvania Avenue Apt 704 Baltimore. Maryl Rev. Mildred Davis 1100 Pennsylvania Avenue Apt 704 Baltimore. Maryl Rev. Mildred Davis 1100 Pennsylvania Avenue Apt 704 Baltimore. Maryl Rev. Maryl Rev. Mildred Davis 1100 Pennsylvania Avenue Apt 704 Baltimore. Maryl Rev. Maryl Rev. Mildred Davis 1100 Pennsylvania Avenue Apt 704 Baltimore. Maryl Rev. Maryl Rev. Mildred Davis 1100 Pennsylvania Avenue Apt 704 Baltimore. Maryl Rev. Maryl Rev												Sumame)		
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206. PLACE AND DATE OF DISPOSITION 206. COATE 206. LOCATION — City or Town, State 206. PLACE AND DATE OF DISPOSITION 1/8 Baltimore, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSES WILLIAM C. BROWN COMMUNITY F/H 1206 W. NORTH AVENUE 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdisc or respiratory arrest, interval Betwoen 1/8		Rev. Mildred Davis	1220 Terming Training The Tot But emilione. Hary tall											
Name and Department			val from State	20b. PLACE	AND DATE	OF DISPOSI	TION (Nar	ne of		OATE	20c. LO	CATION -	City or To	
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdisc or respiratory arrest, shock, or heart failure. List only one cause on such line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): 1 YES 2 NO DUE TO (OR AS A CONSEQUENCE OF): 1 YES 2 NO		4 Donation 5 Other (Specify)		Kin	g Mer	noria	1 Pa	ırk		11/8	Ba	ltimo	ore,	Maryland
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdisc or respiratory arrest, shock, or heart failure. List only one cause on such line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): 1 YES 2 NO DUE TO (OR AS A CONSEQUENCE OF): 1 YES 2 NO	21. SIGNATURE OF FUNERAL SERVICE LICENSES 22. NAME AND ADDRESS OF FACILITY WILLIAM C BROWN COMMINITY F/H													
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DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): 1		disesse or condition								Onset and De				
PART II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Pert i. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO 1 YES 2 NO 1 YES 2 NO	dir.	resulting in death) s. A1D3												
PART II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Pert i. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO 24b. WERE AUTOPSY FINDIN AMALABLE PRIOR TO COMPLETION OF CAUSO OF GEATH? 1 YES 2 NO	Z	harmon and an analysis of the												į
PART II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Pert i. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO 24b. WERE AUTOPSY FINDIN AMALABLE PRIOR TO COMPLETION OF CAUSO OF GEATH? 1 YES 2 NO	NT O	if any, leading to immediate	DUE TO	OR AS A CONSE	OUENCE O	F):								
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PERFORMED? 1 YES 2 NO 1 YES 2 NO 1 YES 2 NO 1 YES 2 NO	i O	PART II Other significent conditions contribution to death but and significant conditions.												
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN DESCRIPTION OF OBJECT OF OBJECT OF CAUSE OF DEATH OF OBJECT OF O	N S	TART II. Other significant conditions	contributing to	deeth but not	resulting	in the un	aeriying	cause ç	given in	Pert I.			248	AMILABLE PRIOR TO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO W UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)	EDI	- or oping												
25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one)	Σ.													
O EXAMINER?	NA.	25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one)												
HOSPITAL: 1 PES 2 NO 1 Inpertant 2 ER/Outpettent 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE AT MERC	YSIC	1 TYES 2 NO		ER/Outpatient	3 🗆 DOA			5 🗆 Re	aldenca	6 Kr Other	(Specify) H	OSPI	CE	AT MERC
ST THE LOS NATURAL ST PROGRAM	5 1						WOF	RK?		28d. DE\$	CRIBE NOW I	NJURY OC	CURED	
2 Accident Investigation 1 YES 2 NO		2 Accident Investigation	26a, PLACE OF	INJURY At h	ome term	tireet facto			NO	201 1 004	TION (Small	ad Momba	. a. D. ant	Do to March
U 4 Homicke determined determined	E G	o Codia not be	building,	ntc. (Specify)		and the state of t	, ome					ria reamble	or murali	nume number,
29s. CERTIFIER 1 CERTIFYING PHYSICIAN: To the head of tru knowledge death occurred of the first	PLE	29a. CERTIFIER 1 CERTIFYING PHYSIC	IAN: To the best of	my knowledge, d	eath occurre	ed at the ti	me, date o	end place.	end due	to the cau	se(e) end mar	ner en ste	ted.	
1 D. III (Check only What is the season of the season of the council at the time, date and place, and due to the causale) and manner as stated	: <u>5</u>													a) and —annes as atotad
29a. CERTIFIER (Check only one) 2 Image: MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end manner se stated. 2 Image: MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) and manner as stated.	0	2 MEDICAL EXAMINER: On the basis of exemination end/or investigation, in my opinion, dasth occurred at the time, date and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)												

5810 BALTO.

RD 21206

30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print)
FERNANDO J. FERRO, MD



TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the brospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunial, cremation, or removal. IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	FOR 1 - STATE REGISTRAR	STATE OF MARYLA			HEALTH AND I	MENTAL HYGIENE REG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last)		02111111			2. DATE OF OEATH		3. TIME OF OEATH		
	Sister Mercita	Healy, RSM				Nov 6, 199	YEAR	11 a. w		
		200	yrs. last birthday)	IF UNDER 1 YEA		7. DATE OF BIRTH (Month, Day, Year)		HPLACE (State or Foreign		
		□ M 2 X F 82	YRS.	MONTHS DAY	HOURS MIN.	Aug 16,1913 Md				
~	9a. FACILITY NAME (If not institution, give street	and number)	VN OR LOCATION OF DE	EATH	Bc. COUNTY OF					
6	The Villa			timore		Ba1ti	Imore			
DIRECTOR	10e. STATE 10b. COUNTY		10c. CIT	Y, TOWN OR LO	CATION			10d. INSIDE CITY LIMITS?		
	Md Bali	timore		Balt i m	ore		1 YES 2 NO			
FUNERAL	100. STREET AND NUMBER 6806 Bellona Avenue				101. ZIP CODE 21212	WHAT COUNTRY?				
N .	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. A FORCES? 1 YES 2				DECENDENT OF HISPAN , specify Cuban, Mexica	NIC ORIGIN? (Specify Yes o	r No — 14. RAC	CE — American Indian, ck, White, etc.		
ВУ	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE WAR OR DAT			YES 2 NO Specifi		Spe	city:		
60	15. DECEDENT'S EDUCAT	ION	18a. DECEDENT'S	USUAL OCCUE	ATION	16b. KIND OF BUSIN	MESS/INVI ISTEV	white		
	(Specify only highest grade con	mpleted) College (1-4 or 5+)		work done during	most of working	Tou. KIND OF BOST	VESS/INDUSTRI			
PL	Ciententary/secondary (0-12)	5+	Religi	ous		Cathol	lic Chur	rch		
COMPLET	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Middle, Maiden St				
BE (Martin Healy				Mary El	len Sweeney	7			
2	19a. INFORMANT'S NAME (Type/Print)					Route Number, City or Town,				
	Sisters of Mercy					, Baltimore		21212		
	20s. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of cemeter). Cemetery, creater place) 20c. LOCATION — City or Town, State									
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY									
	+ Kully	Starles			-	on Funeral		1. 21228		
	23. PART I. Enter the diseases, or con shock, or heart failure. Lis							Approximata Interval Between		
	IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Unlateral plantal affusion works									
_	DUE TO (OR AS, A CONSEQUENCE OF): LONGISTUP PLANT faller MANGE									
CERTIFICATION	Sequentisity list conditions, If any, laading to immediata									
2	Cause. Enter UNDERLYING CAUSE (Disease or Injury C. DUE TO (OR AS A CONSEQUENCE OF)									
Ë	that initiated events resulting in death) LAST	POUE TO (OR AS A CONSEQUENCE OF):								
CE	d									
Ä	PART II. Other significant conditions of	ontributing to death bu	rt not resulting	in the under	ying cause given in	Part I. 24e. WAS AN AI PERFORM		b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO		
PHYSICIAN: MEDIC	ASCUD PERFORMED? AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?									
M	1 YES 2 NO									
AN	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO WUNCERTAIN 125. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)									
S	EXAMINER?	OSPITAL:		OTHER:	Home 5 Th Regidence	# Cother (Constitut				
H	27. MANNER OF DEATH	28e. DATE OF INJURY	28b. TIM	E OF 28c	INJURY AT	26d. DESCRIBE HOW IN.	JURY OCCURED			
ВУ Р	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	IN.	M 1	WORK? YES 2 NO					
ED B	3 Suicida 6 Could not be	28a. PLACE OF INJURY - building, atc. (Special	— At home, lerm,	atreel, lactory,	office	281. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
	4 Homicide datermined									
P.	29a. CERTIFIER (Check only one) (Check only one) (Check only one)									
COMPLET	2 MEDICAL EXAMINER:	On the basis of exemination	and/or investigation	on, in my opinio	on, death occured at the	time, data and place, and	due to the cause	(a) and manner as stated.		
BE	296. SIGNATURE AND TITLE OF CERTIFIER	Do60116	M	0	29c. LICENSE NUI	MBER 923	DATE SIGNE	7/95		
2	30. NAME AND ADDRESS OF PERSON WHO C	OMPLETED CAUSE OF DEA	TH (ITEM 27) (Type	Print) STU	Christe	MD 21	230	1		
	31. DATE FILED (MONS. DATE OF)	32, REGISTRAN'S SIGNA	TURE	7.00	/	1 17 01	- IN			
	7.00 0 0 1333		4.4							

B.K.S

TO BE COMPLETED BY FUNERAL DIRECTOR

BALTIMORE, MARYLAND 21215-0020

Items1&28b,g-729	9,11-8-95,perf.h.,dk
FOR	STATE OF MARYLAND / DE

1 - STATE REGISTRAR	1	STATE OF MA		D / DEPART				MENTAL HYGI			
1. DECEDENT'S NAME (First, MILDRED		N H	JGES	Hughes				2. DATE OF OBATH	DAY 19	9 S	3. TIME OF OEATH
4. SOCIAL SECURITY NUMB				s. last birthday)	IF UNDER t Y	YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH		8. BIRTI	HPLACE (State or Foreign
217-38-9835 9a. FACILITY NAME (If not in		M 2 KF	8				LOCATION OF DE	Iune 6, 1	915	Ma:	ryland
1874 CEDA		,		T I		SADE		etn.			ARUNDEL
RESIDENCE OF DEC	EDENT								AIN	IAT: E	TRONDED
Maryland	Anne	Arundel			asade		N				10d. INSIDE CITY LIMITS? 1 YES 2 X NO
10e. STREET AND NUMBER				10			OF CODE				WHAT COUNTRY?
1874 Cedar							21122			·S·A	
11. MARITAL STATUS 1 Never Merried 2 3 Widowed 4 Divo	Married	FORCES? 1 FIF YES, GIVE WAI	YES 2	NO	If y	yes, speci		NC ORIGIN? (Specify n, Puarto Rican, etc.)		14. RAC Blac Spec	CE — American Indian, ck, Whita, etc. cfly: White
15. OEC	EDENT'S EDUCATI y highest grade con	ION poleted)	164	. DECEDENT'S L	JSUAL OCCU	UPATION	of working	16b. KIND OF	BUSINESS/IN	DUSTRY	111200
Elementary/Secondary (0		College (1-4 or 5+)		life. Do NOT use	retired.)	my most	or working				
12				Housew	ife			Hon			
17. FATHER'S NAME (First, M		0.76				1		ME (First, Middle, Mai	den Sumame)		
Harry		er		105 MAII INC	ADDRESS (S	01		Unkown Route Number, City or			
Patricia I.	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,										22
20a. METHOD OF DISPOSIT	ION		20b. PL/	CEAND DATEO				dena, Mar			
1 Burtal 2 Cremation 4 Donation 5 Other		from State		cremetory or off	per place!						le, Maryland
21. SIGNATURE OF FUNERA	L SERVICE LICENS	2	11100	/.	22. NA	AME AND	ADDRESS OF FA	CILITY			
rancis		czmarek	mp		320)4 M	ountain	al Home o Road, Pa	asaden	a, M	
23. PART I. Enter the di shock, or h		plications that it t Drily one ceus			ot anter th	ne mode	of dying, suc	h as cardisc or re	spiratory s	reat,	Approximate Interval Between
IMMEDIATE CAUSE (Fir		1	1		l- +	. A	Λ				Onset and Death
reaulting in desth)	→ a	Conta DUE TO (C	R AS A CO	NSEQUENCE OF	or (Vou	nd of	Head			
Sequentially list conditi		DUE TO (C	R AS A CO	NSEQUENCE OF):						
cause. Enter UNDERLY	ING										
CAUSE (Disease or Inju		DUE TO (C	R AS A CO	NSEOUENCE OF):						
reaulting in death) LAS	d										
PART II. Other algorifica	int conditions c	ontributing to d	eath but r	not resulting in	the unde	erlying	cause given in	Part I. 24a. WAS	AN AUTOPSY	24	b. WERE AUTOPSY FINDINGS
								PER	FORMED?		AMILABLE PRIOR TO COMPLETION OF CAUSE
											DF DEATH?
DID TOBACCO U	ISE CONTRIB	BUTE TO CAU	SE OF D	EATH YE	S NO	0 🗆	UNCERTAIL	N P	art.ul		
25. WAS CASE REFERRED TO EXAMINER? 1X X ES 2 NO	Н	OSPITAL:		PLACE OF DEAT	OTHER:		5 [YRasidanca	6 Other (Specify)			
27. MANNER OF DEATH		28a. DATE OF M	JURY	28b. TIME	OF 26	8c. INJUF	RY AT	28d. DESCRIBE HO	W INJURY O	CURED	
	Pending Investigation	Fourth, Day	-95-	9:06			S 2 40	subject	shot	self	C
3 Suicide 6	Could not be determined	28a. PLACE OF building, at	INJURY — / c. (Specify)	At home, farm, si		y, office		28f. LOCATION (Str City or Town, S	tate) (87	or or Rural	Route Number,
				1 10 7	uc.			Pavad	and,	Md	a ro
one)								to the cause(a) and time, data and place			(a) and manner as stated.
29b. SIGNATURE AND TITLE	OF CERTIFIER	10.				:	29c. LICENSE NUI	MBER	29d. DA	TE SIGNE	D (Month, Day, Year)
De	1244	& Chi	1k				O.C.M.	E	▶N	OV.	6,1995
30. NAME AND ADDRESS OF		MPLETED CAUSE					. D = 3	1 4 2	16 -		-1 21201
DENNIS	s chu	TEPLE	1	II Pen	n St	ree	et, Bal	timore,	Mar	утаг	nd 21201

TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Nem 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, P.O. BOX 68760

4

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

Item#1.G-film 729 per F.H 11/08/95 P.C

STATE STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

REGISTRAR		CERTIFIC	ATE OF	DEATH		REG. NO.		
SARAH JAMES	arah Matil	lda Hoff	nan Ja	mes	2. DATE OF MONTH NOVE/M	DAY	YEAR 1995	3. TIME OF DEATH
4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) 92 YRS. 6. AGE (In yrs. lest birthday) 92 YRS. 6. AGE (In yrs. lest birthday) 93 YRS. 94 Pounder 24 MRS. 95 Pounder 24 MRS. 95 Pounder 24 MRS. 96 Pounder 24 MRS. 97 Pounder 24 MRS. 98 Pounder 24 MRS. 99 Pounder 24 MRS. 90 Pounder 24 MRS. 90 Pounder 24 MRS. 90 Pounder 24 MRS. 90 Pounder 24 MRS. 91 Pounder 24 MRS. 92 Pounder 24 MRS. 93 Pounder 24 MRS. 94 Pounder 24 MRS. 95 Pounder 24 MRS. 96 Pounder 24 MRS. 97 Pounder 24 MRS. 98 Pounder 24 MRS. 99 Pounder 24 MRS. 90 Pound								γ)
North Arunde Hospital Glen Burnie AA								ЕАТН
RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY		T 40 - OUTH TO	OWN OR LOCAT	104				10d. INSIDE CITY
Maryland Anne	Arundel		n Burni	le				t YES 2 NO
North Arundel Convalescent Cen. 21061 U.S.A.								
11. MARITAL STATUS 1 Never Married 2 Married 1 Never Married 4 Divorced 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO If YES 2 NO DATES 13. WIS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuben, Maxicen, Puerto Ricen, stc.) 14. RACE — American Indian, Black, White, etc. Specify: White							k, White, etc.	
15. DECEDENT'S EDUCA' (Specify only highest grade co		18a. DECEDENT'S USU (Give kind of work life. Do NOT use re	done during mos		16b, Ki	ND OF BUSINESS/	INDUSTRY	
Elementary/Secondary (0-12) 8th	College (1-4 or 5+)	Home Mai	,		0	wn Home		
17. FATHER'S NAME (First, Middle, Last) HE	enry Weyant					Me, Maiden Surnem Smaltz	•)	
19a. INFORMANT'S NAME (Type/Print) Mary Ramsay		734 Bid		nd Number or Rural ad G				nd 21060
20a. METHOD OF DISPOSITION 1 X Burlai 2 Cremetton 3 Removal from Stata 20b. PLACE AND DATE OF DISPOSITION (Name of Conceptor) 20b. PLACE AND DATE OF DISPOSITION (Name of Conceptor) 20b. PLACE AND DATE OF DISPOSITION (Name of Conceptor) 20b. PLACE AND DATE OF DISPOSITION (Name of Conceptor) 20b. PLACE AND DATE OF DISPOSITION (Name of Conceptor) 20b. PLACE AND DATE OF DISPOSITION (Name of Conceptor) 20b. PLACE AND DATE OF DISPOSITION (Name of Conceptor) 20b. PLACE AND DATE OF DISPOSITION (Name of Conceptor) 20b. PLACE AND DATE OF DISPOSITION (Name of Conceptor) 20b. PLACE AND DATE OF DISPOSITION (Name of Conceptor) 20b. PLACE AND DATE OF DISPOSITION (Name of Conceptor) 20b. PLACE AND DATE OF DISPOSITION (Name of Conceptor) 20b. PLACE AND DATE OF DISPOSITION (Name of Conceptor) 20b. PLACE AND DATE OF DISPOSITION (Name of Conceptor) 20b. PLACE AND DATE OF DISPOSITION (Name of Conceptor) 20b. PLACE AND DATE OF DISPOSITION (Name of Conceptor) 20b. PLACE AND DATE OF DISPOSITION (Name of Conceptor) 20b. PLACE AND DATE OF DISPOSITION (Name of Conceptor) 20c. LOCATION — City of Town, Stata								
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY George J. Gonce Funeral Home P.A. 4001 Pitchio Func Raltimore Md. 21225								
Amal Spannerswell 4001 Ritchie Hwy. Baltimore, Md. 21225								
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or reapiratory erreat, ahock, or heart fature. List only one cause on each line.								Approximate interval Batween
IMMEDIATE CAUSE (Finel								Onset and Death
disease or condition reaulting in death) a.	SEPTIC :							
		A CONSEQUENCE OF):						Ì
Sequentially list conditions, b.		CONSEQUENCE OF):	AINON			-		
if any, leading to immediate cause. Enter UNDERLYING	50E 10 (011 A5 A	CONSEGUENCE OF).						j
CAUSE (Disease or injury that initiated events	DUE TO (OR AS /	A CONSEQUENCE OF):						1
resulting in death) LAST								
0.								
PART II. Other aignificant conditions	contributing to deeth t	out not resulting in t	ha underlying	cause given in	Part i. 24	e. WAS AN AUTOP: PERFORMED?	SY 24b	WERE AUTOPSY FINDINGS AMILABLE PRIOR TO
					t	YES 2 NO		COMPLETION DF CAUSE OF DEATH?
								1 YES 2 NO
DID TOBACCO USE CONTRI	BUTE TO CAUSE C	F DEATH YES		UNCERTAI	N 🔀			
25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEATH (
	1 K Inpetient 2 ER/Out	petient 3 DOA 4	THER: Nursing Hom	e 5 🗆 Residence	6 Other (S	(pecify)		
27. MANNER OF DEATH 1 Netural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	26b. TIME O	WO	URY AT RK7 /ES 2 NO	28d. DESCR	IBE HOW INJURY	OCCURED	
2 Accident Investigation 3 Suicide 8 Could not be	28a. PLACE OF INJURY building, stc. (Spe	Y — At home, farm, stree			281. LOCATI City or	ON (Street and Nun fown, State)	nber or Rural i	Route Number,
4 Homicide determined								
29a. CERTIFIER (Check only 1 CERTIFYING PHYSICI	AN: To the best of my know	viedge, desth occurred s	t the time, date	and place, and due	e to the cause	(a) and manner as	stated.	
one) 2 MEDICAL EXAMINER:	On the basis of exemination	on and/or investigation, i	n my opinion, d	esth occured at the	e time, data an	d pieca, and dua t	o the cause(a) and menner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NU	IMBER	29d. I	DATE SIGNED	(Month, Day, Year)
Jun Jon	- MD			P454	55	P 1	NOVEM	BER 3, 1995
30. NAME AND ADBRESS OF PERSON WHO	210 301	HOSPITAL	Y	GLEN	BUAN	E MD	2106	1
31. DATE FILED (Month, Day, Year) NOV 0 8 1995	32. REGISTRAR'S SIGN	MTURE Rawfall			- 144			P

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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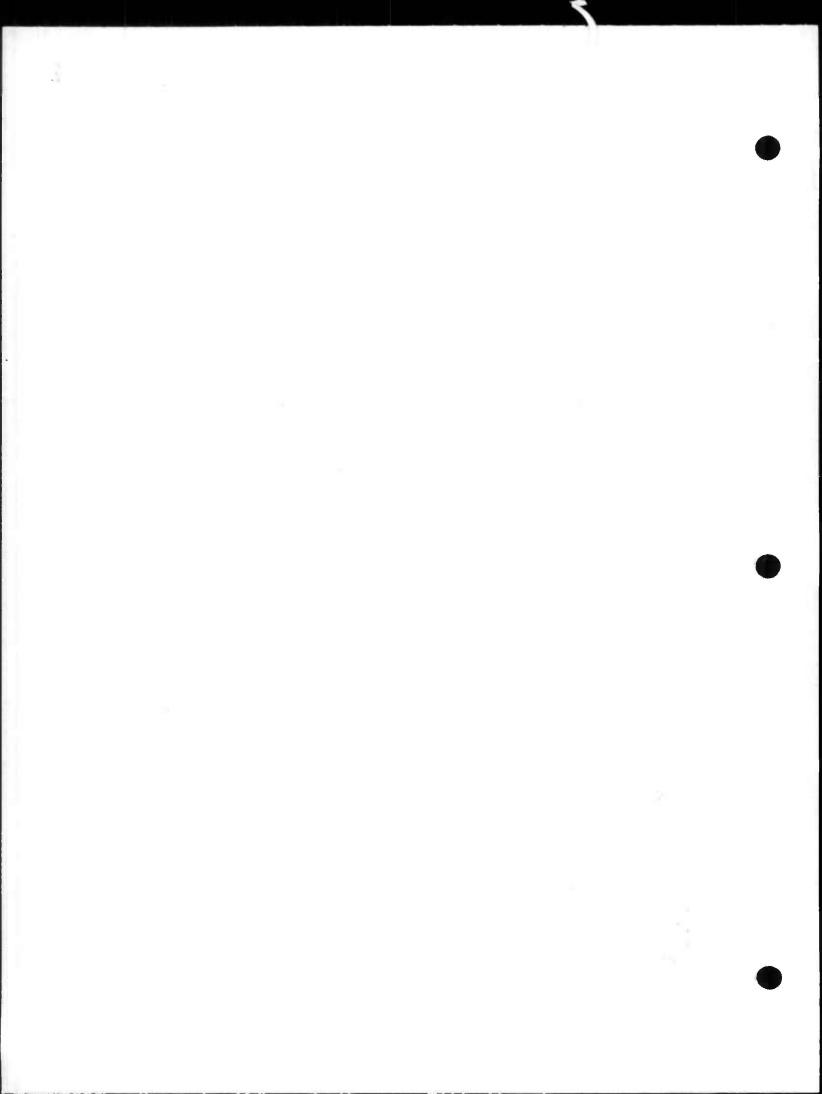
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burkal-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dent, of Realth and Mental Hydiene prior to burkal. cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be negligible as anon
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	1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPART	MENT OF HEALTH AND CATE OF DEATH	MENTAL HYGIENE REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last) A IBERTA	KEN	T		2. DATE OF DEATH DAY	3. TIME OF DEATH 1805em		
	4. SOCIAL SECURITY NUMBER 21470750	5. SEX 6. AGE		F UNDER 1 YEAR IF UNDER 24 HRS. ONTHS DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)		
стоя	90. FACILITY NAME (If not institution, give	OUNTY OF DEATH						
DIRECTOR	100. STATE 10b. COUNT	NA	10c. CITY,	TOWN OR LOCATION		10d. INSIDE CITY LIMITS?		
FUNERAL (10e. STREET AND NUMBER	bur An	POINT	10f. ZIP CODE 2/1	, 10g. C	1 X YES 2 NO CITIZEN OF WHAT COUNTRY?		
	11. MARITAL STATUS 1 Never Merried 2 Merried	12. WAS DECEDENT EVER II FORCES? 1 YES IF YES, GIVE WAR OR D.	2 NO	13. WAS DECENOENT OF HISPA If yes, specify Cuben, Maxie 1 YES 2 NO Spec		Black, White, etc.		
ED BY	3 Widowed 4 Divorced 15. DECEDENT'S EDI		16a. DECEDENT'S US		16b. KIND OF BUSINESS/	Specify: Black		
	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	Give kind of wor life. Do NOT use i	k done during most of working	Sinai	Hospital		
E COMPL	17. FATHER'S NAME (First, Middle, Last)	rick		18. MOTHER'S N	AME (First, Middle, Maiden Surname	3)		
TO BE	19 INFORMANT'S NAME (Type April)	2)	196. MAILING AI	DORESS (Street and Number or Rura	1 Route Number, City or Town, State,	Zip Code)		
	20e, METHOD OF DISPOSITION 1 © Burlel 2 Cremation 3 Rem 4 © Donation 5 © Other (Specify)	noval from State 20b	PLACE AND DATE OF	DISPOSITION (Name of		- City or Town, State		
	21. SIONATURE OF FUNERAL SERVICE LI	CENSEE	1	22. NAME AND ADDRESS OF F		A LANGET CO, 114		
	23. PART I. Eriter the diseases, Dr	complications that caused	the death. Do not	4300 0	walash bu	errest, Approximate		
	ahock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death)	List Drily Drie cause Drie . Melasterti	ech line.	1		Interval Between Onset and Death		
NOI	Sequentially list conditions,	b	CONSEQUENCE OF):					
CERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	c	CONSEQUENCE OF):					
СЕВТ	resulting in death) LAST	d						
DICAL	PART II. Other algnificent condition	na contributing to deeth b	ut not resulting in	the underlying cause given in	Part J. 24a. WAS AN AUTOPS PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
N N	DID TOBACCO USE CONT	RIBUTE TO CAUSE O	F DEATH YES	□ NO □ UNCERTA	IN [2]	1 WES 2 NO		
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? HOSPITAL: OTHER:							
1 4	II 1 V Netural 5 Pending							
TED BY	2 Accident Investigation 3 Suicide 8 Could not be determined							
COMPLETED				nt the time, deta and place, and du				
	29b. SIGNATURE AND TITUE OF CERTIFIE		and/or investigation,	n my opinion, death occured at the		o the cause(e) and manner as atated. PATE SIONED (Month, Day, Year)		
TO BE	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUSE OF DE	MD ATH (ITEM 27) (Type Pr	AK2	143004	11.295		
	31. DATE FILED (Month, Day, Year)	. Khan A	10 Hos	Aberger Build	ing 2435 WF	41 3et sedere 21215		
	NOV 0 8 1995 Jul	32. REGISTRAR'S SIGN	ATURE	,				

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1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH DAY 3. TIME OF DEATH YEAR Olga Kunenetz November 4,1995 1:00 A A SEY S. AGE (fir yrs. lest birthdwy) IF UNDER 1 YEAR IF UNDER 24 HRIS. 7. DATE OF BRITTH B. BUNTHPLACE (State or Foreign Maryland June 27,1927 217-26-5586 1 M 2 XF 68 Se. FACILITY NAME (If not institution, give street and number; Rb. CITY, YOWN OR LOCATION OF DEATH Sc. COUNTY OF DEATH 7 Windmill Chase DIRECTOR permit. Pages 1, 2, 3 Sparks Baltimore RESIDENCE OF DECEDENT 10s. STATE Baltimore HIL CITY, TOWN OR LOCATION 1 YES 2 NO Sparks 10s. STREET AND NUMBER FUNERAL 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 7 Windmill Chase 21152 U.S.A burial-transit the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cutten, Maxican, Puerto Ricen, etc.) 1 YES 2 NO Specify. 14. RACE — American Indian, Black, White, etc. FORCEST 1 YES 2 NO IF YES, GIVE WAR OR DATES 1 Never Married 2 Married BY 3 X Widowed 4 Divorced detached for use as the White COMPLETED 15. DECEDENT'S EDUCATION His. DECEDENT'S USUAL OCCUPATION
(Give Aind of work done during most of working the Do NOT use retreat) ISS. KIND OF BUSINESS/INDUSTRY (Specify only highest grade completed) Elementary/flecondary (0-12) 12 College (1-4 or 5+) Housewife Home 17. FATHER'S NAME (First, Middle, Lest) 18. MOTHER'S NAME (First, Middle, Melden Surname) Page 6 may be retained by the director, page 5 should be of Archie Bychok Christina Kiluk Té BE pellillon THE INFORMANT'S NAME (Type/Print) 19b, MAILING ADDRESS (Street and Number or Flural Floure Number, City or Town, State, Zip Code 2 Christy Medley 411 Lyman Avenue Baltimore, Maryland 21212 ä 20a. METHOD OF DISPOSITION 1 IX Burlet 2 | Cremation 2 | Ra 20b. PLACE AND DATE OF DISPOSITION (Name of 20s. LOCATION -- City or Town, State must funeral director, 4 Donation 5 Other (Specify) 21. SIGNATURE OF TUNEBAL SERVICIPLICEMENT Andrew's Church Cemetery11/8/95 Balto. MD examiner 22. NAME AND ADDRESS OF FACILITY hours after death. The Dippel Funeral Home n and completely filled in by the to burial, cremation, or removal. 7110 Belair Road Balto, MD, 21206 medical 23. PART I. Enter the diseases, or con shock, be heart failure. Lis ns the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betwe IMMEDIATE CAUSE (Final Onset and Death ä Amuscinote cood, our was what Sisease disease or condition resulting in death) event, DUE TO (OR AS A CONSEQUENCE OF): executed traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF). ental Hygiene prior to if any, leading to immediate 8 cause. Enter UNDERLYING CAUSE (Disease or Injury certificate other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST × distill the atte Injury. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. g MEDICAL 24s. WRS AN AUTOPSY 246. WERE AUTOPSY FINDINGS signed by I Health and AVAILABLE PRIOR TO COMPLETION OF CAUSE that amy TO YES 2 NO OF DEATHT shows T WES 2 MO 1 de 1 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 商 P P 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) 2 them Certificate It the State YES 2 NO HOSPITAL: OTHER:
4 | Mursing Home | 5 | Mesidence | 8 | Other (Specify) PHYSICIAN: □ Inpetient 2 □ ER/Outpetient 3 □ DOA 2 6 27. MANNER OF DEATH 28s. DATE OF INJUSTY (Month, Day, Hear) 286. TIME OF INJURY 35c. INJURY AT WORK? aff a marked. 28d. DESCRIBE HOW BLJURY OCCURED 1 X Natural 5 Pending M T YES I NO BY Ather 2 Accident Investigation ATTENDING 28s. PLACE OF INJURY - At home, farm, street, factory, office 281. LOCATION (Street and Number or Rural Route Number, City or Yours, State) 3 🗌 Suicide . # Could not be DIRECTOR. COMPLETED 4 🗌 Homicide 28 Hem 8 29s. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated. FUNERAL within 72 ITANT: II HOSPITAL 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner so stated. TO THE HOSPITA
TO THE FUNERA
De filed within 7
IMPORTANT. 296. SIGNATURE AND PITCE OF CERTIFIER 29c. LICENSE NUMBER 29d, DATE SIGNED (Morth, Day, Year) BE come 2 by MANE AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Charles F. O' Donnell MD. 111 Hamlett Hill Rd. Balto.Md 21210 Ali Bander Rede



REG. NO.

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

Leonard **KREPKA** 4. SOCIAL SECURITY NUMBER 216-05-5098 5. SEX 6. AGE (In yrs. last birthday) IF UNDER I YEAR 7. DATE OF BIRTH (Month, Day, Year, IF UNDER 24 HRS. 1X M 2 F 76 use as the burial-transit permit. Pages 1, 2, 3 should 9s. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH Franklin Square Hospital DIRECTOR Rossville RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION Baltimore Rosedale FUNERAL 10e. STREET AND NUMBER 101, ZIP CODE 301 Patapsco Ave. 21237 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 1 Never Married 2 X Married If yes, specify Cuban, Mexican, Puerto Rican, etc.) YES 2 NO BΥ Specify: 3 Widowed 4 Olvorced WW II COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EOUCATION (Specify only hi ğ Secondary (0-12) UNK unk. Steel Worker page 5 should be detached 17. FATNER'S NAME (First, Middle, Last) Adam Krepka K BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Doris Krepka 301 Patapsco Ave. Baltimore, MD must be 20e. METNOD OF DISPOSITION
1X Burial 2 Cremetion 3 Removal from State 20b. PLACE AND OATE OF DISPOSITION (Name of OATE funeral director, Gardens of Donation 8 - Other (Specify) Faith 11-6-95 examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND AODRESS OF FACILITY 710/1 was Call the attending physician and completely filled in by the 1 Mental Hygiene prior to burial, cremation, or removal. medical 23. PART I. Eyer the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or haert failure. List only one cause on each line. IMMEDIATE CAUSE (Final 鲁 disease or condition . Septic Shock resulting in dasth) traumatic event, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with DUE TO (OR AS A CONSEQUENCE OF): PHYSICIAN: MEDICAL CERTIFICATION ⊾ Vascular Disease Sequentially list conditions. if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disesse or Injury or other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST Injury. PART II. Other significent conditions contributing to desth but not resulting in the underlying ceuse given in Pert I. signed by the shows any Coronary artery disease, abdominal aortic aneurysm t, of F DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES X NO X UNCERTAIN X has be Dept. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) certificate I HOSPITAL: OTHER: 1 YES 2 X NO 1 X Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) marked, or 27. MANNER OF CEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT this (1 🔀 Natural 5 Pending DIRECTOR: After the hours after death vittem 28 is mark BY 1 YES 2 NO 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) 3 Sulcide COMPLETED 8 Could not be 4 Homicide Hea 29a. CERTIFIER

(Chack only

1 🔀 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(a) and manner as stated. TO THE HOSPITAL
TO THE FUNERAL (
be filed within 72 h
IMPORTANT: If II HOSPITAL 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, data and piece, end due to the cause(s) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIES 29c LICENSE NUMBER 0 D36663 Q 30. NAME AND AGORESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

2. DATE OF DEATH DAY 3. TIME OF CEATH YEAR November 1995 11:43 a B. BIRTHPLACE (State or Foreign 2-18-19 MD 9c. COUNTY OF CEATH Baltimore County 10d. INSIDE CITY 1 YES 2 X NO 10g. CITIZEN OF WHAT COUNTRY? USA 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian, Black, White, etc. Specify: white 16b. KIND OF BUSINESS/INDUSTRY Steel Production 18, MOTNER'S NAME (First, Middle, Maiden Surname) Mary Labiendzieska 21237 20c. LOCATION - City or Town, State Baltimore MD orela Approximats interval Between Onset and Death 4 hours vears 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF OEATH? PERFORMED? 1 TYES 2 X TINO 1 - YES 2 - NO 28d. DESCRIBE NOW INJURY OCCURED 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 29d. DATE SIGNED (Month, Day, Year) November 3, 1995 Loch Raven Boulevard #512 Baltimore, MD DNMH-18 Rev 1/89

Stuart R.

M.D.

5601

32. RESISTRAR'S SIGNATURE

Willes

strong Age 188

TO THE HOSPITAL OR ATTENDING PRINCIPAL THE ISW requires that the death certificate be executed whom 24 hours after death. Page 6 may be retained by the hospital or attending phy	THE FUNERAL DIRECTOR. And this care has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bur the filled within 72 hours after director, page 5 should be detached for use as the bur the filled within 72 hours after director, page 5 should be detached for use as the bur on the burn of the filled within 12 hours after the page 12 hours after the page 13 hours after the page 13 hours after the page 14 hours after the page 14 hours after the page 14 hours after the page 15 hour	IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	
TR ATTEN	MRECTOR:	em 28 h	150
PUM O	ERAL DI	九月日	
ME HOS	AE FUN	DRITAR	
5	日本	IMP	

	1 - FOR STATE OF MARY	LAND / DEPARTMENT CERTIFICATE		MENTAL HYGIEN		33304
	1. DECEDENT'S NAME THUI, Middle, Lbst)	KEEVE		2. DATE OF DEATH MONTH D	AY GY	an 8:15 A M
	4. SOCIAL SECURITY NUMBER 200-84-8499 98. FACILITY NAME (If not institution, give street and number)	(In yrs. lest birthday) IF UNDER MONTHS SHOULTY	1 YEAR IF UNDER 24 HRS. DAYS HOURS MIN. TOWN OR LOCATION OF D	7. DATE OF BIRTH (Month, Day, Year) Oct. 30	0	BIRTHPLACE (State or Foreign Country) NEW YORK
TOR	BON SECOURS HOSPITAL	-	ALTIMORE_CI			N/A
DIRECTOR	10a. STATE 10b. COUNTY MARYLAND N/A	10c. CITY, TOWN D BALT	R LOCATION IMORE CITY			10d. INSIDE CITY LIMITS? t Y YES 2 ND
	100. STREET AND NUMBER 2310 Riggs Avenue Apt.	13	10f. ZIP CODE 21219		10g. CITIZEN	OF WHAT COUNTRY?
BY FUNERAL	tt. MARITAL STATUS 1 X Never Married 2 Married 3 Widowed 4 Divorced 12. WAS DECEDENT EVER FORCES? t YES IF YES, GIVE WAR OR (IN U.S. ARMED 13. 1	MAS DECENDENT DF HISPAI f yes, specify Cuban, Mexica T YES 2 X NO Specifi	an, Puerto Ricen, etc.)	e or No 14.	RACE — American Indian, Black, White, etc. Specify: BLACK
COMPLETED	ts. DECEDENT'S EDUCATION (Specify only highest grade completed) Elamentary/Secondary (0-12) College (1-4 or 5+) 12th grade	16a. DECEDENT'S USUAL OF (Give kind of work done of life. Do NOT use retired.) Nurses Aid	during most of working	16b. KIND OF BU		
BE CON	17. FATHER'S NAME (First, Middle, Lest) Peter Miller			ME (First, Middle, Melden		
TO B	196. INFORMANT'S NAME (Type/Print) Betty V. Toulson	196. MAILING ADDRESS 104 Augus	ta Dr. Blue	Bell. Pa.	n, State, Zip Cod	ie)
	1X Buriel 2 Cremation 3 Removal from State C8	W	,	11/4 He		le, Va. 22473
	23. PART Enter the diseases, or complications that cause abock, or heart failure. List only one ceuse on IMMEDIATE CAUSE (Final disease or condition resulting in death) OUE TO (OR AS	d the deeth. Do not enter	the mode of dying, suc	Aug.	ratory arreal.	Approximata interval Between Onset and Death
CERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	A CONSEQUENCE OF): A CONSEQUENCE OF):				
MEDICAL	PART II. Other significant conditions contributing to deeth DID TOBACCO USE CONTRIBUTE TO CAUSE	DE DEATH YES I	NO UNCERTAL	1 🗆 YES	RMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 ND
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 ND HOSPITAL: 110 Inpetient 2 ER/Out	26. PLACE DF DEATH (Check tpatient 3 DOA 4 Num		8 Other (Specify)		
ву РН	27. MANNER OF DEATH 1 Natural 5 Pending (Moreh, Day, Year) 2 Accordant Investigation	289. TIME OF INJURY M	28c. INJURY AT WORKY 1 YES 2 NO	28d. DESCRIBE HOW	INJURY DOCURE	10
	a C Sections	tY — At home, form, street, fect ecdy)	ory, office	281, LOCATION (Street City or Xwer, State		lurel Route Mumber
COMPLETED	29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my kno only) 2 MEDICAL EXAMINED! On the basis of examinating					suse(s) and manner as stated.
BE	296. SIGNATURE AND TITLE OF CENTIFIER	M. R.	DAC LICENSE NU	and the second second		ONED (Morris Operator)
0	36. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DE	W. Baltimore	Stroot	21223		1.1.1.3
	NOV 0 8 1995	MATURE MATURE	Sureet	61663		

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8. BIRTHPLACE (State or Foreign Country) Md

Approximata Interval Between Onset and Daath 2 mos

24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?

1945

3. TIME OF OEATH

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)
ALBERT

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	4. SOCIAL SECURITY NUM	BER	5. SEX	6. AGE (In yrs.	last birthday)			-					8. BIRTHPL	ACE (State or Foreign
	215-16-90	13X M 2 🗆 F 74 YRS.			MONTHS DAYS HOURS MIN.						d			
	9a. FACILITY NAME (If not institution, give street and number)					9b. CITY, TOWN OR LOCATION OF OEATH					9c. COUN			
8	2106 Fern	ølen	Way			Car	tons	27717	10			Rell	+imo	re
5	RESIDENCE OF DE	CEDENT							10			Dai	OTINO	16
뿐	10a. STATE	10b. COUNT	Y		10c. CI1	Y, TOWN	OR LOCAT	ION					10	d. INSIDE CITY
	Md.	Ba	ltimore	9	Ça	tons	svil	le					1	YES 2 NO
AL	10e. STREET AND NUMBER						101	. ZIP COD	E			10g. CITIZ	EN OF WHA	T COUNTRY?
<u> </u>	2106 Fern	glen	Way-Cat	tonsvi	lle.	Md.			21	228		U	.S.A	
5	11. MARITAL STATUS					13.	WAS DEC	ENDENT C	OF HISPAN	IIC ORIGIN?	(Specify Yea		14. RACE -	American Indian.
					JNU						can, etc.)		Specify:	/hita, atc.
		11531	8-42										W	hite
핕	15. DEC (Specify on	CEDENT'S EDU ly highest grade	CATION completed)		(Give kind of	work done	during mo	ON st of working	ng	16b, I	KIND OF BUS	INESS/INDU	JSTRY	
<u>"</u>	Elementary/Secondary (0-12)		+)		,								
Z	Grade 12		2 Year	cs S	team	shir	o Ag	ent			John	S.	Conn	or
8		,						18. MOT	HER'S NA	ME (First, Mi	ddle, Maiden	Sumame)		
ш			on	_				A	nne	Fol	ev			
	19a. INFORMANT'S NAME (Type/Print)			19b. MAILING	ADDRES	\$ (Street a	nd Number	r or Rural F	Route Numbe	r, City or Town	n, State, Zip	Code)	
-	Mary G. K	night	on		2106	Fer	rngl	en	Wav.	-Cat	onsv	ille	. Md.	21228
	200 METHOD OF DISPOSIT	ION 3 D Boo	and the State		CEANDDATE	OF DISPOS	SITION (Na							
	4 Donation 5 Other	r (Specify)	OVER FROM STATE	Cemetery,	Cat	her place)	ral	Cem	.11.	-10-	95	Ralt	0	Md
	21. SIGNATURE OF FUNERA	IN SERVICE LIK	PNGEE			22.	NAME AN	ID ADDRE	SS OF FA	CILITY				
	•	11	Tem	De 1	met								l Pi	ke
\vdash	G. Truman Schwab Baltimore, Md. 21229													
	ehock, or h	liseasea, or o leart fallure.	complications the List only one ca	et caused the use on each li	death. Do ine.	not enter	r the mo	de of dy	ing, aucl	h aa cardii	nc or reapl	ratory arri	eat,	Approximata Interval Between
		nal		1 1	4		•			•				Onset and Das
	resulting in death)	\rightarrow	. The	tastal	ic C	arc	ing	ma	100	is				2 mos
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Z	Sequentially list condit	lone C					Can	Ru	un	4				1 yr
Ĕ	If any, leading to imme	diete	DUE TO	(OR AS A CON	SEQUENCE O	F):								U
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E I	that initiated events		DUE TO	OR AS A CONS	SEOUENCE O	F):								
ER	readiting in death) EAS		d											ļ
	PART II. Other eignifica	ant condition	a contributing to	death but no	t resuiting	in the u	nderivino	Cause (alven in	Part I	24a WASAN	ALITOPSV	24b W	ERE AUTOPSY FINDING
8	arterio	sclere	This Cou	diam	4. 94	. /	hio	MAG			PERFOR	MED?	AM	MILABLE PRIOR TO OMPLETION OF CAUSE
<u> </u>					000000	16	Park	BO'THE		-	1 YES 2	NO		F DEATH?
Σ	DID TORACC	O HICE	CONTRACTOR IS		110= 0								1	YES 2 NO
N N			COMIKIBUI	E IO CA	USE O	F DEA								
ᅙᅵ	25. WAS CASE REFERRED T EXAMINER?	O MEDICAL	HOSPITAL:			OTHE		ACE OF D	EATH (Chi	ock only one				
YS	1 YES 2 NO				3 □ DOA			• 5 XPI	sidenca	6 🗆 Other	(Specify)			
표		Prodice			26b. TIN	JURY	WO	RK?		28d. DESC	RIBE HOW IF	NJURY OCC	URED	
	2 Accident	Investigation				M			NO					
			26s. PLACE (building	OF INJURY — At , atc. (Specify)	home, farm,	street, fac	tory, office					nd Number	or Rural Rout	e Number,
	V Homiciae	Gettinined.												
PL	29a. CERTIFIER (Check only	TIFYING PHYS	CIAN: To the best of	f my knowledge,	death occurr	ed at the	time, data	and place	, and dua	to the cause	e(a) and man	ner aa state	d.	
OM														nd manner as stated.
	29b. SIGNATURE AND TITLE	OF CERTIFIE	R fad					29c. LICI	ENSE NUM	IBER		29d DATE	SIGNED /L	Ingth Day Year)
	Ancres	4 14	mille	~ M	4			A	06	987		> /	1/2/	4
임	30. NAME AND ADDRESS O	F PERSON WH	O COMPLETED CAU	ISE OF DEATH (TEM 27) (Type	Print)		W	عرب	102		- "	10	1-
	JOSEPH						701	1 A	12	Bas	etm	ie 1	nd:	21229
	NOV 0 8199	Soar)	PANELSTR	AL VAN	E									
	BY PHYSICIAN: MEDICAL CERTIFICATION TO B	215-16-90 98. FACILITY NAME (If not is 2106 Fern Residence of Detail 10s. STATE Md. 10e. STATE Md. 10e. STREET AND NUMBER 2106 Fern 11. MARITAL STATUS 11. MARITAL STATUS 11. Never Married 2 X 3 Widowed 4 Diversion of Detail 15. Detail	215—16—9008 99. FACILITY NAME (If not institution, give is 2106 Fernglen RESIDENCE OF DECEDENT 100. STATE 100. COUNT Md 100. STREET AND NUMBER 2106 Fernglen 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced 15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12) Grade 12 17. FATHER'S NAME (First, Middle, Last) Philip Knight 190. INFORMANT'S NAME (Type/Print) Mary G. Knight 200. METHOD OF DISPOSITION 1 NBurlet 2 Cremation 3 Ram 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL PRINCE LAST WIMMEDIATE CAUSE (Final disease or condition resulting in death) NOTE TO BE CAUSE (Final disease or condition resulting in death) NOTE TO BE CAUSE (Final disease or condition resulting in death) NOTE TO BE CAUSE (Plast of any leading to Immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DID TOBACCO USE 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 6 Could not be detarmined 290. CERTIFIER (Check only one) 2 MEDICAL EXAMINE 290. SIGNATURE AND TITLE OF CERTIFIER (Check only one) 2 MEDICAL EXAMINE 290. SIGNATURE AND TITLE OF CERTIFIER (Check only one) 2 MEDICAL EXAMINE 290. SIGNATURE AND TITLE OF CERTIFIER (Check only one) 2 MEDICAL EXAMINE 290. SIGNATURE AND TITLE OF CERTIFIER (Check only one) 2 MEDICAL EXAMINE 290. SIGNATURE AND TITLE OF CERTIFIER (Check only one) 2 MEDICAL EXAMINE	215-16-9008 2 M 2 F 98. FACILITY NAME (If not institution, give street and number) 2106 Fernglen Way RESIDENCE OF DECEDENT 108. STATE 108. STATE 109. STATE	215—16—9008 March Family The street and number The street and number	Separation of Disposition Specific and State Separation Specific and State Separation Specific and State Specific and State Separation Specific and State Spe	Separation Sep	215-16-9008 ID N 2 F 74 YRS. SOUTH SAME (If not institution, pive sheet and number) 96. FACILITY NAME (If not institution, pive sheet and number) 97. FACILITY NAME (If not institution, pive sheet and number) 98. FACILITY NAME (If not institution, pive sheet and number) 99. CITY, TOWN OR LOCAL TOWN OR L	215-16-9008 22 M 2 F 74 VRS. SOFTISE DATE DOWN ON INCOME. 2106 FOR FOREIGN WAY CATONSVII 100. STATE 100. STA	215-16-9008	215-16-9008	215_16_9008 Control Control Caton statistics pie enter and number) Caton Statistics Caton statistics pie enter and number Caton Statistics Caton Stati	215—16—9008	215-16-9008

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

KNIGHTON

2. DATE OF OEATH

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DHMH-16 Rev 1/89

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funeral director, page 5 should be detached for use as the burial-transit

completely filled in by the

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31. DATE FILED (Month, Day, Year)

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DIVISION OF VITAL RECORDS, P.O. BOX 68760	DSPITAL OR ATTENDING PHYSICIAN: The
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH REG NO 1. OECEDENT'S NAME (First, Middle, Last, 2. DATE OF DEATH 3. TIME OF DEATH 95 Arthur Lehmann 1:50 05 November 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year 6. BIRTHPLACE (State or Foreign 83 212-05-4613 1 M 2 F YRS Sept.05 1912 Maryland 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY. TOWN OR LOCATION OF DEATN 9c. COUNTY OF DEATH DIRECTOR Fairhaven Health Care Center Sykesville Carroll RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Carroll County Maryland Sykesville 1 X YES 2 NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 7200 Third Avenue 21784 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Merried BY 3 X Widowed 4 Divorced Specify: White COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KINO OF BUSINESS/INDUSTRY (Specify only high Elementary/Secondary (0-12) College (1-4 or 5 +) /i Engineer Engineering 17. FATNER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) te Anthony A. Lehmann BE Katherine Schlieder notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Christina Lehmann Aske 26E. Aylesbury Road Timonium, Md. 21093 9 20a. METNOD OF DISPOSITION
1 ☐ Burlet 2 🖔 Cremation 3 ☐ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE must Carroll oche eller 4 Donation 6 Other (Specify) 11/6/95 Hampstead.Md. examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSFI 22. NAME AND ADDRESS OF FACILITY Harry P.O.Box 195 Sykesville, Md. medical 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of learn failure. List only one cause on each line. Approximate Interval Bstween 6 IMMEDIATE CAUSE (Finel Onset and Death the disease or condition_ PNEUMONIA ASPIRATION days event, 1 resulting in death) DUE TO (OR AS A CONSEQUENCE OF): PARKINSON'S burial, DISEASE years traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): Hygiene prior to if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury the attending physician Mental Hygiene prior to other i DUE TO (OR AS A CONSEQUENCE OF): that initiated eventa resulting in death) LAST 6 PART II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24s. WAS AN AUTOPSY PERFORMED? MEDICAL signed by the any 1 TYES 2 NO OF DEATH? Shows 1 YES 2 NO t, of H DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO 🗷 UNCERTAIN 🗆 PHYSICIAN: Dept. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) certificate h h the State (tem HOSPITAL OTHER: 1 YES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA Nome 5 - Residence 6 - Other (Specify) 6 27. MANNER OF DEATH 26a. DATE OF INJURY marked, 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE NOW INJURY OCCURED DIRECTOR: After this c hours after death with Natural 5 Pending Investigation 1 YES 2 NO BY 2 Accident 28s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Sulcide 281. LOCATION (Street and Number or Rural Route Number, City or Town, Stete) 69 6 Could not be COMPLETED 4 Nomicide 28 29e. CERTIFIER 1 X CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(a) and manner as stated. FUNERAL within 72 h 2 MEDICAL EXAMINER: On the beele of axamination and/or investigation, in my opinion, death occurred at the time, data and place, end due to the cause(a) and manner as stated. TO THE HOSPITA
TO THE FUNERA
De filed within 7. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE IL. MD 34849 111 6/95 2 30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

ELDERSBURG

MD

21784

ROAD

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3. TIME OF DEATH

REG. NO.

2. DATE OF DEATH

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FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

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1995 YEAR DAY Nov. 3-1;05 P William R. Milstead 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year) 8. AGE (In yrs. last birthday) 8. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR IF UNDER 24 HRS. 1 X M 2 | F HOURS 216-74-0937 34 Nov 5,1960 Md Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street end number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 521 Sussex Rd. Towson Baltimore RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10e. STATE 10d. INSIDE CITY Md. Baltimore Towson 1 TYES 2 X NO permit. 10e. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? FUNERAL 10f. ZIP CODE 521 Sussex Road 21286 use as the burial-transit USA 11. MARITAL STATUS
12 Never Merried 2 Merried 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 € NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-if yes, specify Cuben, Mexican, Puerto Ricen, atc.) 14. RACE — American Indian, Black, White, etc. 1 YES 2 NO Specify: Specify BY 3 Widowed 4 Divorced white COMPLETED 16s. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade co Elementary/Secondary (0-12) College (1-4 or 5+) funeral director, page 5 should be detached for 10 Interior Designer Designing once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Melvin G. Milstead 70 Nancy Lee notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 521 Sussex Road, Towson, Md. Nancy Milstead pe 20e. METHOD OF DISPOSITION
1 Burlel 2 A Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION --- City or Town, State must 4 Donetion 6 Dother (Specify) Chesapeake Crematory Beltsville, Md. examiner 21. SIGNATURE FINERAL SERVICE LICENS 22. NAME AND ADDRESS OF FACILITY ailly Bradley Ashton Funeral Home lailes filled in by the figure, or removal. 2134 Willow Spring Road, Dundalk, 21222 Md, medicai 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heert feilure. List only one cause on each line. Approximate Interval Between Onset and Death IMMEDIATE CAUSE (Final cremation, the disease or condition resulting in death) . WASTING SYNDROME the attending physician and completely i Mental Hygiene prior to burial, cremati event, DUE TO (OR AS A CONSEQUENCE OF): KAPOST'S SMOOMA traumatic CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to Immediate cause. Enter UNDERLYING CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events reaulting in death) LAST 50 PART II. Other aignificant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24e. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS been signed by the of Health and I AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PERFORMED? Esophagitis, ufractory shows any 1 - YES NO 1 YES 2 NO certificate has been h the State Dept. of DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL EXAMINER?

1 YES 2 NO 26. PLACE OF DEATH (Check only one) Item HOSPITAL:
1 | Inpatient 2 | ER/Outpatient 3 | DOA OTHER: 4 Nursing Home 5 Reeldence 5 Other (Specify) 0 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED with marked, Natural this 5 Pending Investigation 1 YES 2 NO BY DIRECTOR: After the hours after death vitem 28 is mark death 2 Accident 28e. PLACE OF INJURY — At home, ferm, street, fectory, office building, stc. (Specify) 281. LOCATION (Street end Number or Rural Route Number, City or Town, State) 3 Suicide COMPLETED 8 Could not be 4 Homicide determined 29e. CERTIFIER (Check only Check on Ch FUNERAL | within 72 h 2 MEDICAL EXAMINER: On the beels of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) end manner es stated. TO THE HOSPITA
TO THE FUNERA
De filed within 7
IMPORTANT: 1 29h. SIGNATURE AND THE OF CENTIN Da 85 44 29d. DATE SIGNED (Month, Day, Year) 器 03/95 2 SP NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27 (Type, Print)

OUT D. JUGE, MO 1001 CUTTED AT ST md

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

B.K.S

ITEMS: 23 PART I, 27, PER MEO FILM 6-730 12/20/95 t.t Item4 11-8-95 FilmG729 W.H.Per F/H

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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYCICHE

	1 - STATE REGISTRAR		SIAIE UF I		ERTIF					MENIA	REG. NO				
	1. DECEDENT'S NAME (First, M	Aiddle, Last)									E OF DEATH		YEAR	3. TIME OF DEATH	
	SALVATOR	E	J. MA	RANTO	IR	JR.				NO.		1438 P M			
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. In		IF UNDER			R 24 HRS.	7. DATE	OF BIRTH		9.5 8. BIRTH	PLACE (State or Foreign		
	217-93-920	9	1 🖺 M 2 🗌 F	77	YRS.	MONTHS	DAYS	HOURS	MIN.		th, Day, Year)	1918	Country	rvland	
	9a. FACILITY NAME (If not instit	itution, give s				9b. CITY	r, TOWN C	R LOCAT	ION OF DE				NTY OF D	7	
5	NORTHWEST I	HOSP	ITAL CE	NTER		RA.	NDAI	LLSI	OWN			BA	LTI	MORE	
מטוטשוות	RESIDENCE OF DECE				_										
	200	10b. COUNT			10c. CIT	Y, TOWN	OR LOCAT	ION					G =	10d. INSIDE CITY LIMITS?	
	Md.		Carrol	L		S	ykes							1 YES 2 NO	
\$	10e. STREET AND NUMBER					101	ZIP COD	-					WHAT COUNTRY?		
UNERAL	6349 Pi	iney	Ridge Dri					217				U.S			
L [1 Never Married 2 M	larried		X YES 2		13.	If yea, sp	elfy Cubi	en, Mexica	n, Puerto	N? (Specify Yes Rican, etc.)	or No—	Black	E — American Indian, c, White, etc.	
2	3 🗶 Widowed 4 🗌 Divorce	ed	IF YES, GIVE W	AR OR DATES			1 YES	2 X NO	Specify	y:			Whi		
3		DENT'S EDU		18a. D	ECEDENT'S	USUAL O	CCUPATIO)N		16	b. KIND OF BU	SINESS/INC			
	(Specify only h Elementary/Secondary (0-12		College (1-4 or 5	- III	Give kind of e. Do NOT u	work done se retired.)	during mo	st of work	ing						
	10				Car	pent	er				Cor	stru	ctio	n	
COMPLE	17. FATHER'S NAME (First, Midd							113			Middle, Maiden	Sumame)	**		
U C	Salvatore		ph Marant	o, Sr.		_			Sara	h Ci	trino				
5	19a. INFORMANT'S NAME (Type			15							nber, City or Tow				
-	Patty Rosen				-				Vestn		ter, M				
	20a. METHOD OF DISPOSITION 1 № Burlet 2 □ Cremetion	3 🗆 Rem	oval from State	20b. PLACE cemetery, cr	ematory or o	ther place	J			DA		CATION —			
	4 Donation 5 Other (S		CENCEE	Lake	View				rk 1		0/95 Sy	kesv	ille	, Md.	
	41.	1.1	17 ' 11			-	. HAME A				uneral	Hom	e		
	Hamy	<u>70.</u>	Hought		11						ville,			84	
	23. PART I. Enter the disc shock, or has	esses, or art fallure.	complications the List only one cau	t caused the d se on aach lin	seth, Do	not ente	r the mo	de of dy	ing, suc	h ss ce	rdisc or resp	iratory sr	rest,	Approximate Interval Between	
- 1	IMMEDIATE CAUSE (Final disease or condition	ı	- TT. 10000						_					Onset and Death	
	resulting in death)		P1		R AS A CONSEQUENCE OF):										
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ALION	Sequentially list condition if any, leading to immedia		b. DUE TO	(OR AS A CONSE											
3	cause. Enter UNDERLYIN	G	c.												
	CAUSE (Disease or Injury that Initiated events Due TO (OR AS A CONSEQUENCE OF):														
	resulting in death) LAST		d												
ונ	PART ii. Other significant	t condition	ns contributing to	death but not	rasulting	In tha u	nderlyin	cause	given in	Part i.	24s. WAS AN	AUTOPSY	24b	. WERE AUTOPSY FINDINGS	
5											PERFO			AMILABLE PRIOR TO COMPLETION OF CAUSE	
MED	-										T M YES	Z NO		OF DEATH?	
- 1	DID TOBACCO US	E CONT	RIBUTE TO CA	USE OF DEA	ATH Y	ES 🗆	NO K	UN	CERTAI	ΝП				1 YES 2 NO	
SICIAN	25. WAS CASE REFERRED TO				CE OF DEA										
2	EXAMINER?	557/Outpatient	3 DOA	OTHE 4 - Nu		e 5 🗆 R	lesidence	8 🗆 Ott	ner (Specify)						
	27. MANNER OF DEATH		28a. DATE OF	INJURY	28b. T/N	E OF	28c. INJ	URY AT			ESCRIBE HOW	INJURY OC	CURED		
	1 Natural 5 Pe	ending vestigation	(Month, E	ay, rear)	"	JURY		RK? YES 2	NO						
	3 Suicide 8 C	ould not be	28e. PLACE C	F INJURY — At h	ome, farm,	street, fed	tory, offic	•			CATION (Street y or Town, State		r or Rural F	Soute Number,	
u	4 Homicide de	etermined		,						J	, 0, 10, 11, 0, 0, 0				
MFLEI	29a. CERTIFIER 1 CERTIF	YING PHYS	ICIAN: To the best of	my knowledge, d	leath occur	ed at the	time, date	and place	e, end due	to the c	ause(a) and me	nner aa ste	ted.		
5	one) 2 X MEDICA	AL EXAMINE	ER: On the basis of e	xamination end/or	Investigati	on, In my	opinion, d	eath occu	red at the	time, da	te and place, a	nd due to t	he cause(s	a) and manner as stated.	
	296 SIGNATURE AND TITLE	CERTIFIE	R /					29c. LIC	ENSE NU	MBER		29d. DA	E SIGNED	(Month, Day, Year)	
	Maurite	Mel	Mule	÷				0.	C.M.	. E		▶ N	ov.	7,1995	
-	30. NAME AND ADDRESS OF	PERSON WI	O COMPLETED CAU	SE OF DEATH (IT	EM 27) (Type	, Print)	h								
	MAINDULL	7 17	· CORE		Pen	11 51	rree	E,	BgT.	LIMO	ore, r	ary	Tanc	1 21201	
	31. DATE FILED (Month, Day, 8	1995	HE MISTE	R'S VGNATUR	delle										

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Memtal Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

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	1 - STATE REGISTRAR	STATE OF MA					DEAT		VIEN IAL	REG. NO				
	t. DECEDENT'S NAME (First, Middle, Lest)				TOAT I		DLA		2. DATE O	F DEATH			3. TIME OF DEATH	
		Lola La	raine	Pri	etz				MOVE		av 7 1	995	12:43 A.M	
	4. SOCIAL SECURITY HUMBER 5. SEX 6. AGE (In yrs. less birthday)					1 YEAR	IF UNDER		7. DATE O	BIRTH		BIRTH	IPLACE (State or Foreign	
	212 36 1326	1 🗆 M 2 🔀 F	59	YRS.	MONTHS	DAYS	HOURS	MIN.		Day, Year)	1936	Mar	yland	
	9a. FACILITY NAME (If not institution, give stre	et and number)			9b. CITY	, TOWN C	R LOCATIO	N OF DE			-	NTY OF D		
R	Harbor Hospita:	l Center			Ba1	timo	ore				N/2	A		
5	RESIDENCE OF DECEDENT													
DIRECTOR	100.000	e Arundel			y, rown o		IOH						tod. INSIDE CITY LIMITS?	
	Maryland Anne	Arunder		Do	11011		. ZIP CODE			_	40. 017	1300 05 1	t TYES 2 N HO	
FUNERAL	The state of the s	23				101							WHAT COUNTRY?	
N N	116 Cedar Hill I	KOAQ 12. WAS DECEDENT E	VED IN ITS. ADI	MED	1 +2	WAS DEC	212		IIC ORIGIN?	(English Va		J.S.A		
B	t Hever Married 2 Married	FORCES? t	YES 2 XN			It yes, sp	ecify Cube	ı, Mexicai	n, Puerto Ri	en, etc.)	5 OF 140-	100 000 000	E American Indian, k, White, etc.	
	3 Widowed 4 Divorced	IF TES, GIVE WAR	OR DATES			I L TES	2 X HO	apeany	<i>(:</i>			Spec	White	
B	t5. DECEDENT'S EDUCA (Specify only highest grade or	TIOH probleted)	16a. DE0	CEDENT'S	USUAL O	CCUPATIO	ON st of workin		t6b.	IND OF BU	SIHESS/IH	DUSTRY		
🖫	Elementary/Secondary (0-12)	College (t-4 or 5+)	life.	Do NOT u	se retired.)	ourning mo	SI OF WORKE	9						
COMPL	7th		C	Leani	ing					Funer	al H	ome		
8	17. FATHER'S HAME (First, Middle, Last)		D3-1	_			18. MOTH		ME (First, Mi					
H		lmer Vern							vada					
9	tea. IHFORMANT'S HAME (Type/Print)						nd Number		Poute Numbe				nd 21225	
151	Fred Prietz		_			_		au				Maryland 21225		
	20a. METHOD OF DISPOSITION t X Burlal 2 Cremation 3 Remove	val trom Stata		EAHD DATE OF DISPOSITIOH (Name of rematory or other place)					DATE 20c. LOCATION — City or Town, State					
	t XBurlai 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cedar Hill Cemetery 11/10 Baltimore, Maryland 2t. SIGNATURE OF FUNERAL BEHVICE LICENISE 22. HAME AND ADDRESS OF FACILITY													
	George J. Gonce Funeral Home P.A.													
	Honna M framusache 4001 Ritchie Hwy. Baltimore, Md. 21225													
	23. PART i. Enter the diseases, or to ahock, or heart failure	mplications that c	aused the de	ath. Do i	not enter	the mo	de of dyi	ng, sucl	h as cardi	c or resp	iratory a	reat,	Approximate Interval Between	
	ahock, or heart fature List only one cause on each line.									Onset and Death				
	disease or condition resulting in death)	_ chi	orie	2 A	thi	al	K	mi	lla	tien	n			
		DUE TO (OI	R AS A CONSEC	DUENCE O	F):	,								
N	disease or condition resulting in death) a. Chronice Atrial Fibiliation DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, b. Headership Cardiovascular disease													
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING													
5	CAUSE (Disease or Injury													
🗒	that initiated events reaulting in death) LAST													
E	d.													
CAL										. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO				
								1 TYES 2 NO				COMPLETION OF CAUSE OF DEATH?		
ME									t 🗌 YES 2 🗍 HO					
ä	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO SUNCERTAIN													
SICIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLAC	E OF DEA	TH (Check									
YSI	1 ☐ YES 2 XNO	1 Inpatient 2 X E		□ DOA			e 5 🗆 Re	sidenca	8 🗆 Other	(Specify)				
PHY	27. MANNER OF DEATH t X Hetural 5 Pending	28e. DATE OF IN. (Month, Day,		28b. TIN	JURY	WO	URY AT		28d. DEȘCRIBE HOW IHJURY OCCURED					
BY	Z Accident Investigation				М		YES 2	НО						
입	3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF II building, etc	HJURY — At ho :. (Specify)	me, farm,	street, tac	tory, offic	4			TON (Street Town, State		or Rural i	Route Number,	
ᇤ														
COMPL	(0110011 0111)	IAH: To the best of my												
ő	2 MEDICAL EXAMINER	On the basis of exam	nination and/or i	Investigation	on, In my	opinion, d	leeth occur	ed at the	time, data a	nd placa, a	nd due to t	the cause(s) and manner as stated.	
	296. SIGNATURE AND TITLE OF CERTIFIER 296. DATE SIGNED (MONT), Day, West													
l W	MD D17743 11/7/95													
00							-	.53		_	- 1	. 1	US	
TO BE	30. HAME AND ADDRESS OF PERSON WHO		OF DEATH (ITE	M 27) (Type	o, Print)	, 10	uu,	124	UTIN	ORE	, MI	7, 2	1225	

Pages 1. 2. 3 should

permit.

DIRECTOR

FUNERAL

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2

CERTIFICATION

MEDICAL

PHYSICIAN:

BY

COMPLETED

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2

TO THE HOSPITAL OF THE FUNERAL DE FILE WITHIN 72 H

HOSPITAL

27. MANNER OF DEATH

1 Netural
2 Accident

3 Suicide

4 Homicide

95 33570 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO 2. DATE OF DEATH DAY 1. DECEOENT'S NAME (First, Middle, Last) 3. TIME OF DEATH YEAR 5,1995 Virginia 4. SOCIAL SECURITY NUMBER November 7:00 Price 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) DEC 24 IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 215-44-8304 87 1 M 2 X VA 1907 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Maryland General HOspital Baltimore Baltimore city RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY TOWN OR LOCATION 10d. INSIDE CITY MD N/A BALTO t X YES 2 NO 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 1137 N. GILMORE ST 21217 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married If yes, specify Cuben, Maxican, Puerto Rican, etc.) 1 - YES 2 17 NO Specify: Specify: 3 Widowed 4 Divorced BLACK 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify ntary/Secondary (0-12) 12th College (1-4 or 5+) N/A NURSES AIDE HOSPITAL 17. FATNER'S NAME (First, Middle, Lest) 18. MOTNER'S NAME (First, Middle, Maiden Surname) **GEORGE** HOLIDAY NANNIE PRICE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) BETTY WHITE 2911 THORNDALE AVE BALTO, MD 21215 20a. METHOD OF DISPOSITION
1 [XBurial 2 | Cremation 3 | Ramoval from State 20h PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State OATE "KINGMEMORIAL 4 Donation 5 Other (Specify) 11995 PARK RANDALLSTOWN, MD 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY MARCH F/H-WEST 4300 WABASH AVE 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate ahock, or heart fellure. List only one cause on each line. interval Betw IMMEDIATE CAUSE (Final Onset and Death disease or condition_ Arrhythmia resulting in death) unknown DUE TO (OR AS A CONSEQUENCE OF) Arteriosclerotic Vascular Disease Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF) cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF) that initisted events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE 1 | YES 2 NO OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATN (Check only one) HOSPITAL OTHER: 1 TES 2 NO 4 Nursing Nome 5 Residence 8 Other (Specify)

1 ☐ Inpatient 2 ☑ ER/Outpetient 3 ☐ DOA 28a. OATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 5 Pending

28c. INJURY AT WORK?

28d, DESCRIBE NOW INJURY OCCURED 1 YES 2 NO 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

D3127

1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. (Check only one)

2 MEDICAL EXAMINER: On the bests of examination and/or investigation, in my opinion, death occurred at the time, data and placa, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNEO (Month, Day, Year)

OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Azra Arned, M.D. c/o Maryland General Hospital

AM RECISTRAR'S SIGNATURE

8 Could not be

▶ November 6,1995

Items# 1.9.a.19.b.G-film 729 per F.H 11/08/95 P.C

1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) Thomas 2. DATE OF DEATH 3. TIME OF DEATN Christian Pniewski NOVEMBER, YEAR 9-30 A.H 06,1995 4. SOCIAL SECURITY NUMBER 5. SEX 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State or Foreign 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 1 M 2 | F DAYS 213-18-7712 07/ 24/1914 as the burial-transit permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and Harbor Hospital 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Baltimore N/A RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? 1 YES 2 NO N/A **Baltimore** FUNERAL 10a. STREET AND NUMBER 10f ZIP CODE 16 S. Patterson Pk. Ave. 21231 IISA retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EYER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian, Black, White, etc. BALTIMORE, MARYLAND 21215-0020 If yes, specify Cuban, Mexican, Puerto Ricen, etc.)

1 YES 2 NO Specify: 1 Never Married 2 Married BY Specify: 3 Widowed 4 Divorced 5 34 ...
16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) White ETED 15. OECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY use (Spe detached for Elementary/Secondary (0-12) College (1-4 or 5+) COMPL INKNOWN Sheet Metal Worker Coast Guard 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname) notified at BE Joseph Pniewski Sophie Chmielewska page 5 should 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Chester St. 19a. INFORMANT'S NAME (Type/Print) 2 John Pniewski Ave Baltimore, Md. 21231 Раде 6 тау be Patterson Pk must be 20a. METHOD OF DISPOSITION

1 Burlel 2 Cremation 3 Removal from State 20h. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - Cify or Town, State funeral director, 4 Donation 8 Other (Specify) Holy Rosary Cemetery 11-10 Baltimore Md examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE hours after death. David J. Weber Funeral Homes and completely filled in by the oburial, cremation, or removal. 23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, medicai Approximata shock, or heart fellure. List only one cause on each line. Interval Batwee IMMEDIATE CAUSE (Final CONGESTIVE HEART FAILURE Onset and Death the disease or condition 22 DAYS reaulting in daath) traumatic event. DUE TO (OR AS A CONSEQUENCE OF): SEPSIS 22 DAYS CERTIFICATION Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF): prior to signed by the attending physician Health and Mental Hygiene prior to if any, leading to immediate 22 DAYS cause. Enter UNDERLYING CAUSE (Disease or Injury CELLULITIS RIGHT LEG DUE TO (OR AS A CONSEQUENCE OF): that initiated eventa resulting in death) LAST PERIPHERAL VASCULAR DISEASE 2 months PART II. Other aignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY STATUS VASCULAR POST SURGERY 1 YES 2 WHO OF DEATN? 1 TES 2 LING has been s Dept. of H DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN D PHYSICIAN: HOSPITAL OR ATTENDING PHYSICIAN: The law 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) r this certificate h with the State [HOSPITAL: 1 YES 2 NO 4 Nursing Home 5 Residence 8 Other (Specify) 6 27. MANNER OF DEATN marked, 28a. DATE OF INJURY 26c, INJURY AT WORK? 28b. TIME OF INJURY 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending 1 YES 2 NO DIRECTOR: After the hours after death w BY investigation 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 40 3 Sulcide 6 Could not be COMPLETED 90 4 Homicide Hem 29a. CERTIFIER

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and menner as stated. TO THE HOSPITAL OF THE FUNERAL DE FILED WITHIN 72 h 2 MEDICAL EXAMINER: On the besia of as ition and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated, Intern (PGY-1) 29b. SIGNATURE AND TITLE OF CENTIFIE BE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) NOVEMBER 06 1995 AS2441614-14 9 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print)
SUDHIR KUMAR AGGARWAL, HARBOR HOSPITAL CENTER, BALTIMORE, MD Jall Editerateur Rendull

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALLIMORE, MARTLANI	JAHYLAN
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hos	stained by the hos
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the aftending physician and completely filled in by the funeral director, page 5 should be detachy be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal,	should be detach
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	otified at once.

FOR 1 - STATE	STATE OF MARYLAN											
REGISTRAR 1. DECEDENT'S NAME (First, Middle, Last)		CERTIFIC	ALE OF	DEATH	T	REG. NO.		la -				
	I I DO I I				2. DATE OF MONTH	DAY		EAR	IME OF DEATH			
MARTIN H. PHIL 4. SOCIAL SECURITY NUMBER		rrs. last birthday) I	F UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF				11:34 E (State or Fore	PM		
216-30-0898 9a. FACILITY NAME (If not institution, give s	1 X M 2 □ F 60	O YRS.	ONTHS DAYS	HOURS MIN.	AUG.	ny, Year)	935	Country) MA	RYLAND	gn _		
		,	BALT1	R LOCATION OF DE	ATH		9c. COUNTY	Y OF DEATH				
10a. STATE 10b. COUNTY			TOWN OR LOCAT					100	INSIDE CITY			
	<u>A</u>	BA	LTIMORE	ZIP CODE			10g. CITIZE	-	YES 2 N			
100. STREET AND NUMBER 613 SOUTH CHARLE 11. MARITAL STATUS 1 Never Married 2 Married	S STREET		101	21230				S.A	COUNTRY?			
11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 N Divorced	12. WAS DECEDENT EVER IN U. FORCES? 1 YES	2 X NO	If yes, sp	ENDENT OF HISPAN ocity Cuban, Mexica 2 X NO Specify	n, Puerlo Rica		or No — 14	Black, Whi	merican Indian			
15. DECEDENT'S EDU		Sa. DECEDENT'S US			16b. Kil	ND OF BUSI	NESS/INDUS		MALLE			
Elementary/Secondary (0-12)	(Specify only highest grade completed) (Give kind of work done during most of working life. Do NOT use retired.) (Give kind of work done during most of working life. Do NOT use retired.)											
17. FATHER'S NAME (First, Middle, Lest)	12 GLASS WORKER GLASS											
MARTIN H. PHILLIPS, SR. AUDREY HUM												
19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3425 E. BALTIMORE STREET, BALTIMORE, MD 21224												
20a. METHOD OF DISPOSITION 20b. PLACE AND DATE Of DISPOSITION / Name of cemetery, cremetory or other place) 20c. LOCATION — City or Town, State												
4 Denetion 5 Other (Specify) LOUDON PARK CEMETERY 11/03/95 BALTIMORE, MARYLAND 21. SIGNATURE OF ANNIA ANNIA DELICITY												
LOUDON PARK FUNERAL HOME, INC. 3620 WILKENS AVENUE, BALTIMORE, M									D 212	29		
23. PART f. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ahock, or heart failure. List only one cause on each line.												
IMMEDIATE CAUSE (Final disease or condition resulting in death) SEPTIC SHOCK										Deatl S		
	resulting in death) a. SISTITO STOCK DUE TO (OR AS A CONSEQUENCE OF):											
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	RESPIRATORY DISTRESS 7 DAYS											
If any, leading to immediate												
cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST CONGESTIVE HEART FAILURE DUE TO (OR AS A CONSEQUENCE OF):												
DART II Other significant conditions contribution to doubt but not resulting in the underlying to the underlying the underlying to the underlying the underl												
S	PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY PERFORMED? ANNUA COMPL											
1 TYES 2 X NO OF DI									DEATH?			
DID TOPACCO LISE CONT	DID TOP ACCOUNTS CONTRIBUTE TO CAUSE OF DEATH, MES TO ANO THE UNICEPTAIN TO											
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN S. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one)												
EXAMINER?	HOSPITAL:		OTHER:									
	1 YES 2 X NO 1 Xnpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify)											
	27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY WORK? 1 YES 2 NO											
2 Accident towestigation 3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJURY — building, etc. (Specify)	At home, ferm, str.				ON (Street ar lown, State)	nd Number or	Rural Route	Number,			
200 CERTIFIER												
one)	ICIAN: To the best of my knowled											
2 MEDICAL EXAMINE	ER: On the basis of examination a	ind/or investigation,	in my opinion, o	eath occured at the	time, date an	d place, end	due to the	cause(a) and	l manner ee ati	ted.		
296. SIONATURE AND TITLE OF CENTURE	9///	- /		29c. LICENSE NUI	MBER		29d. DATE S	SIGNED (Mor	nth, Day, Year)			
TO NAME AND ADDRESS OF HERSON WIL	It no	4nter	っ	AS24416	14-30		NO	VEMBE	R 1, 1	995		
30, NAME AND ADDRESS OF HURSON WIL	O Edado ETEO CAUSE OF DEAT	H (TEM 27) /Som (S	NOW.									

Alabamat Tarak

ITEMS: 23 PART I. 27. PER MEO FILM G-730 12/13/95 t.t

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 1995 NOVEMBER IMBERLY POWELL 6:10 PM. Ν 7. DATE OF BIRTH 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In vrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (S or Foreign DAYS HOURS 1 M 2 L Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEAT BAYVIEW MEDICAL BALTIMORE CITY OPKINS CENTER DIRECTOR RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY 1 FYES 2 NO permit. FUNERAL 10f. ZIP CODE 10a. CITIZEN OF WHAT COUNTRY? as the burial-transit retained by the hospital or attending physician. 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-It yes, specify Cuber, Maxican, Puerto Rican, etc.)

1 YES 2 Specify: S DECEDENT EVER IN U.S. AF 14. RACE - American Indian FORCES? 1 YES 2 2 1 Never Married 2 Married BY 3 Widowed 4 Divorced ETED. 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUS use College (1-4 or 5+) ğ COMPL page 5 should be detached once. 17. FATHER'S NAME (First, Middle, Last MOTHER'S NAME (First, Middle Ħ BE notified 2 after death. Page 6 may be 99 20a. METHOD OF DISPOSITION 1 Buriel 2 Cremeton 20b. PLACE AND DATE OF DISPOS must funeral director, 4 T Donat examiner SERVICE LICENSES filled in by the medical complications that caused the death. Do not enter heart fallura. List only one cause on each line. SHING interval Between ŏ Onset and Death IMMEDIATE CAUSE (Final the disease or condition SYSTEMIC LUPUS ERYTHEMATOUS WITH COMPLICATIONS completely resuiting in death) other traumatic event, DUE TO (OR AS A CONSEQUENCE OF) burial, CERTIFICATION and Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): 2 If any, leading to immediata cause. Enter UNDERLYING HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be prior CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF) that initiated avents attending reaulting in death) LAST 6 d by the atten Injury, PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS MEDICAL AVAILABLE PRIOR TO COMPLETION OF CAUSE any signed by Health ar 1 TYES 2 NO OF DEATH? shows a 1 YES 2 NO been of h DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN s certificate has been the the State Dept. of PHYSICIAN: 23 26. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL Hem HOSPITAL:
1X Inpatient 2 ER/Outpatient 3 **EXAMINER?** OTHER: 1 X YES 2 NO 0 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28b. TIME OF 28d. DESCRIBE HOW INJURY OCCURED with t marked, XX Natural 1 YES 2 NO BY OIRECTOR: After the hours after death 2 Accident 28s. PLACE OF INJURY — building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, 3 Suicide 69 6 Could not be COMPLETED 28 4 Homicide item 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and menner as stated. TO THE HOSPITAL OF THE FUNERAL OF THE WITHIN 72 PM IMPORTANT: If its 2XXMEDICAL EXAMINER: On the basis agemination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and menner as stated, 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE C.M.E 3,1995 2 DEATH (ITEM 27) (Type, Print) GOL JR. 111 Penn Street, Baltimore, Maryland 21201 IE

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BALTIMORE, MARYLAND 21215-0020 BOX 68760 DIVISION OF VITAL RECORDS, P.O.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hosp	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be defacthed	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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	1 - FOR STATE REGISTRAR	STATE OF MARYLAN	ID / DEPARTMENT OF CERTIFICATE OF		NTAL HYGIENE REG. NO.					
20	1. DECEDENT'S NAME (First, Middle, Lest)	y L. RANKIN		2.	DATE OF DEATH	1995	3. TIME OF DEATH A			
3	4. SOCIAL SECURITY NUMBER 413 -98 - 1562	5. SEX 6. AGE (In y)	HOURS MIN.	DATE OF BIRTH (Month, Day, Year)	Country)	PLACE (State or Foreign)				
TOR	9a. FACILITY NAME (If not institution, give of 2008 Wilson Discount Company)	7 15	9b. CITY, TOWN	OR LOCATION OF DEATH		BALTIM	ATH LOLE			
DIRECTOR	10a. STATE 10b. COUNT	LTI MORE	10c. CITY, TOWN OR LOCA				10d. INSIDE CITY LIMITS? 12 YES 2 NO			
FUNERAL	10a. STREET AND NUMBER	POINT RD		2/220	10	g. CITIZEN OF WI				
BY FUR	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U.S FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES	2 NO If yes, s	CENDENT OF HISPANIC (pecify Cuben, Mexican, P 8 2 NO Specify:	ORIGIN? (Specify Yes or Noverto Rican, etc.)	Black, Specify	American Indian, White, etc.			
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	CATION 16: completed) College (1-4 or 5+)	a. DECEDENT'S USUAL OCCUPAT (Give kind of work done during m life. Do NOT use retired.)	ost of working	16b. KIND OF BUSINES	SS/INDUSTRY	7/12			
	17. FATHER'S NAME (First, Middle, Last)	A MAR	HOMEMAKEN	18. MOTHER'S NAME	(First, Middle, Malden Surne					
TO BE	190. INFORMANT'S NAME (Type/Print) CHARLES RE	nkin	19b. MAILING ADDRESS (Street 2008 W; LS	7)	11001	ete, Zip Code)	1. 2/220			
	20e. METHOD OF DISPOSITION 1	oval from State 20b. PL.	ACE AND DATE OF DISPOSITION (A			EENE	n, State			
	21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE O. Skarly	G. SKA	IND ADDRESS OF FACILITY	"2829 HUZ	DSON ST MD 213				
	23. PART I. Enter the disease, or ahock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in desth)	complications that caused the List only one cause on each a. Due to join as a co	Ine.	ode of dying, such as	a cerdiec or reapirator	ry arrest,	Approximate interval Between Onset and Death			
CERTIFICATION	Sequentially list conditions, if any, laading to immediata cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF):									
EDICAL C	PART II. Other algorificent condition		not resulting in the underlying	ng cause given in Par	t i. 24a. WAS AN AUTO PERFORMED 1 UES 2	3/	WERE AUTOPSY FINDINGS WAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?			
Σ	DID TOBACCO USE CONT		/	UNCERTAIN [1	YES 2 NO			
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	26. (HOSPITAL: 1 Inpatient 2 ER/Outpatient	PLACE OF DEATH (Check only one OTHER: nt 3 DOA 4 Nursing Hor	ne 5 Residence 6 🗆	Other (Specify)					
BY PH	27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME OF 28c. IN INJURY	-	d. DESCRIBE HOW INJUR	Y OCCURED				
8	3 Suicide 6 Could not be determined	umber or Rural Rol	zie Number,							
COMPLET		ICIAN: To the best of my knowledge: R: On the best of examination en					and menner ee stated.			
TO BE CO	SIGNATURE AND THREE DE CERTIFIES	inter		29c. LICENSE NUMBER		L DATE SIGNED (A				
-	30. NAME AND ADDRESS OF PERSON WH Charles (Morry), Person WH 31. DATE FILED (Morry), Person (Mr)	COMPLETED CAUSE OF DEATH		6 Merri	tt Blud	Bul	to mo zizzz			
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FOR STATE REGISTRAR

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	1. DECEDENT'S NAME (First, Middle, Last) HARRY JOSEPH ROBINSON 2. DATE OF OEATH MONTH DAY YEAR 3. TIME OF OEATH MONTH NOV B 1995														
	134111			•					NOV 6 1995				3:04 pi		
	4. SOCIAL SECURITY NUMBER 5. SEX 1 № M 2 □ F 8. AGE (In yrs. last b)					IF UNDER T	DAYS	HOURS	MIN.	(Mon	th, Day, Year)	,1910	Coun	HPLACE (State or Fore try) Md	
	9a. FACILITY NAME (If not in	nstitution, give o	street and number)			1	9b. CITY,	TOWN O	R LOCATI	ON OF DE			·	NTY OF I	DEATH
CTOR	Saint Joseph Medical Center Towson, Maryland Baltim							more							
2	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY				- 11	10c. CITY,	TOWH OF	LOCAT	ION						10d. INSIDE CITY
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ERAL	152 N. Curi		eet					101.	212				10g. CIT		SA
BY FUN	11. MARITAL STATUS 1 Never Married 2 🔀 3 Widowed 4 Divo		12. WAS DECEDER FORCES? IF YES, GIVE V	X YES	2 NO		it	yes, spe		n, Maxica	n, Puerlo	N? (Specify Y Rican, etc.)	es or No—	Spec	E — American Indian ck, White, atc. city:
ED	15. DEC	CEDENT'S EDU	CATION COmpleted	1	16a. DECEI	DENT'S U	SUAL OC	CUPATIO	N et of weeki	20	16	b. KIND OF B	USINESS/IN		HE
PLET	(Specify only highest grade completed) Elamentary/Secondary (0-12) College (1-4 or 5 +)			+)	life. Do	ppin	retired.)		or works	79		Lum	ber C	ompa	ny
COMPL	17. FATHER'S NAME (First, N	Aiddle, Last)	-						16. MOT	HER'S NA	ME (First,	Middle, Maide	n Surname)		
w l	Edwin Alfred	d Robi	nson							a Sh			,		
TO B	19a. INFORMANT'S NAME (on									nber, City or R			224
	20a. METHOD OF DISPOSIT				PLACEAND	DDATEO	FDISPOSI				DA		OCATION -		
	1 X Burial 2 ☐ Crematic 4 ☐ Donation 5 ☐ Other		noval from Stata	cemet	tary, cremai	itory or oth	er place)				11/				
	21. SIGN THE OF PURE ALL DEVICEACENSEE Sacred Heart of Jesus 11/10 Baltimore, Md. 22. NAME AND ADDRESS OF FACILITY Moran Ashton Funeral Home														
	1 Kitu	J.K	telas	_										0146	, Md. 212
	IMMEDIATE CAUSE (Fit disease or condition resulting in death)	naart fallura.	complications the	E MAS	ch line.	INTR	ACEF	the mo	de of dy	ing, suc	h sa ce				Approximatinterval Bet Onset and
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

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TILE ASSESSATION BY CLAY BUTT

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DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL ORECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

1. DECEDENT'S NAME (First, Middle, Last)

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	1. DECEDENT'S NAME (First, Middle, Last)	011.		2. DATE OF DEATH		3. TIME OF DEATH				
,	Margaret	Kobbins		NOU 5	1995	6:30 P. m				
1	4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. lost birth 2/5-24-3457 1 \(\text{ M 2 \(\text{Q} \) F \(\text{ 65} \) Y	HONTHS DAY		7. DATE OF BIRTH (Month, Day, Year)	8. BIRT Cour	HPLACE (State or Foreign itry)				
İ	9a. FACILITY NAME (If not institution, give street and number)	96. CITY, TO	N OR LOCATION OF DEA	ATH	9c. COUNTY OF	DEATH				
DIRECTOR	4010 Belvieu Avenue	Bal	timore		1	IA				
ñ	10e. STATE 10b. COUNTY 10	c. CITY, TOWN OR LO	CATION			10d. INSIDE CITY				
	Md NA 100. STREET AND NUMBER 4010 BEIVIEU AVENUE	Baltin	nore			1 X YES 2 NO				
FUNERAL	- HID Boly in Aug.		2/2/	_	10g. CITIZEN OF	WHAT COUNTRY?				
N	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED	13. WAS	DECENDENT OF HISPANI	C ORIGIN? (Specify Yea	or No 14. RA	CE — American Indian, ck, White, atc.				
	1 Never Married 2 Married FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES		, specify Cuban, Maxican YES 2 NO Specify:							
ВУ	3 Wildowed 4 Divorced					Black				
TED	(Specify only highest grade completed) (Give kii	ENT'S USUAL OCCUP and of work done during		16b. KIND OF BUS	SINESS/INDUSTRY					
COMPLET	Elementary/Secondary (0-12) College (1-4 or 5 +)	NOT use retired.)		Pat	ala.					
N N	17. FATHER'S NAME (First, Middle, Last)	014	10 MOTHED'S NAM	E (First, Middle, Maiden	Sumamal					
	Lenn White		huara	Li K	107	1				
BE	199/ INFORMANT'S NAME (Typg/Print) , 19b. MA	ALING ADDRESS (Str	eet and Number or Rural A	oute Number, City or Town	n, State, Zip Code)	Tyre				
2	hinda Smith 40	10 Be	luien Ave	TIME IN	a Ho md	21215				
	20e, METHOD OF DISPOSITION 11 Burial 2 Cremetion 3 Ramoval from Stala 4 Donation 6 Other (Specify)	DATE OF DISPOSITION by or other place)	Part	11/11/gs XC	chdall	stown, state				
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	23. NAM	THE H. W	Part		21215				
	Humis D. Harris	1-700	4300	wabash	Are 1	Ba Ho, Md				
	23. PART I. Enter the disesses, or complications that caused the death. ahock, or weent failure. List only one cause on each line.	Do not enter the	mode of dying, such	as cardiac or respi	ratory srrest,	Approximats interval Between				
	IMMEDIATE CAUSE (Final	0	100			Onset and Death				
	disease or condition a. 1990and	led o	march	45						
	DUE TO (OR AS A CONSEQUEN	ICE OF):	0							
CERTIFICATION	Sequentially list conditions, Due to (OR AS A CONSEQUEN	NCE OF):								
SAT	If any, leading to immediate cause. Enter UNDERLYING									
Ĕ	CAUSE (Disease or injury thet initieted events DUE TO (OR AS A CONSEQUEN	NCE OF):								
ERI	resulting in death) LAST									
	PART II. Other significent conditions contributing to geath but not resul	Iting in the under	ying cause given in 6	Part I. 24s. WAS AN	AUTOPSY 24	Ib. WERE AUTOPSY FINDINGS				
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ED	1/2 trecular Tachusen	10		1 YES 2	NO	OF DEATH?				
M										
IAN	25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF	F DEATH (Check only	,							
PHYSICIAN:	EXAMINER? 1 YES 2 NO HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 D	OTHER:	Home A Residence	6 Other (Specify)						
Ŧ	27. MANNER OF DEATH 280. DATE OF INJURY 28	b. TIME OF 28c	INJURY AT	28d. DESCRIBE HOW I	NJURY OCCURED					
ВУР	1 Netural 5 Pending 2 Accident Investigation (Month, Day, Year)	INJURY M 1	WORK?							
	3 Suicida 8 Could not be 28e. PLACE OF INJURY — At home, building, atc. (Specify)	farm, street, fectory,	office	281. LOCATION (Street of City or Town, Stete)		l Route Number,				
COMPLETED	4 Homicide detarmined			Only or rown, Stelley						
PE	29a. CERTIFIER (Check only CERTIFYING PHYSICIAN: To the best of my knowledge, death of	occurred at the time,	data and place, and due	to the cause(e) end mar	nner as stated.					
₩ O	one) 2 MEDICAL EXAMINER: On the heats of exemipetion and/or invest					e(a) and manner as stated.				
296. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Day, Year)										
0	CLA		1025	244	11/	788				
임	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27)	(Type, Print)	0 .	1	-/-	10				
	M KEHMAN.	3800	W. Belv	edere	Balt	0 Med 21215				
	NOV 0 8 1995	Call				′				

3. TIME OF DEATH

10d. INSIDE CITY LIMITS?

1 XXYES 2 NO

STATES

BLACK

AVENUE

Interval Between

Onset and Death

unknown

AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?

1 YES 2 NO

29d. DATE SIGNED (Month, Day, Year)

November 7,1995

11:30 A

FOR

REGISTRAR

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1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH Month Day 6,1995 Streat 4. SOCIAL SECURITY NUMBER 5 SEX 6. AGE (in yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH IF UNDER 24 HRS. B. BIRTHPLACE (State or Foreign FEB. 19, 1893 216-10-5532 1 M 2 XEY VIRGINIA 98 be detached for use as the burial-transit permit, Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH maryland General Hospital DIRECTOR **Baltimore** Baltimore City RESIDENCE OF DECEDENT 10b. COUNTY 10c CITY TOWN OR LOCATION MARYLAND BALTIMORE n/a FUNERAL 10a. STREET AND NUMBER 101. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 501 FRANKLIN STREET 21201 UNITED retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS OECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ∑ NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE - American Indian, Black, White, etc. If yes, specify Cuben, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 1 Never Married 2 Married ВҰ 3XX Widowed 4 ☐ Divorced Specify: COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working 15. DECEDENT'S EDUCATION 16b. KINO OF BUSINESS/INQUSTRY 12 th College (1-4 or 5+) HOUSEWIFE in own home 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname) ALBERT COUSTNS SALLIE BROWN BE funeral director, page 5 should notified 19a. INFORMANT'S NAME (Type/Print)
NOEL WILLIS Aurel Acute Number, City or Town, State, Zip Code)
CIRCLE apt.C, BALTIMORE, MD#04 2 tred within 24 hours after death. Page 6 may be a completely filled in by the funeral director, page 5 rial, cremation, or removal. must be 200 METHOD OF DISPOSITION 20c. LOCATION — City or Town, State 20b. PLACE AND DATE OF DISPOSITION /Name of DATE ~ARBUTUS ~ ~MEMORIAL PARK 11-8 ARBUTUS, MD 4 Donation 8 Other (Specify) examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY WM. C. MARCH FH.-1101 E. NORTH the medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line inding physician and completely filled in Hygiene prior to burlal, cremation, or r IMMEDIATE CAUSE (Final disease or condition resulting in death) Coronary Artery Disease
DUE TO (OR AS A CONSEQUENCE OF): traumatic event, executed Oral Cavity Cancer CERTIFICATION Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate attending physician death certificate be cause. Enter UNDERLYING CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 0 signed by the atten Health and Mental H PART II. Other aignificant conditions contributing to daeth but not reaulting in the underlying cause given in Part i. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS that Old Cerebro-Vascerlar Accident any 1 - YES 2 NO requires 1 shows a DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: Dept. 23 has 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) State certificate HOSPITAL: 1 TES 2 NO OR ATTENDING PHYSICIAN: 1 Inpetient 2 DER/Outpetient 3 I DOA 4 Nursing Home 5 Realdence 8 Other (Specify) the 27. MANNER OF DEATH 28c. INJURY AT WORK? 28e. DATE OF INJURY 28b. TIME OF 28d. DESCRIBE HOW INJURY OCCURED with t marked, 1 X Natural ΒY 1 YES 2 NO After death 2 Accident DIRECTOR: Aft hours after des item 28 is n 28e. PLACE OF INJURY — At home, ferm, street, fectory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 Homicide TO THE HOSPITAL OR AT TO THE FUNERAL DIRECT DE filed within 72 hours a IMPORTANT: If item 2 29e. CERTIFIER (Check only one)

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(e) and manner as stated. 2 MEDICAL EXAMINER: On the besis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER

T. Seudelsman, M. D.

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Inna Gendelsman, M.D. c/o Maryland Gneral Hospital

32. REGISTRAR'S SI

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

29c. LICENSE NUMBER

DHMH-18 Rev 1/89

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 flours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: It liem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be netified at once.

FOR STATE REGISTRAR	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL CERTIFICATE OF DEATH	HYGIENE REG. NO.
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	1 - STATE REGISTRAR	SIAIE UF MARY		ICATE OF		MENTA	L HYGIEI				
1	1. DECEDENT'S NAME (First, Middle, Last) CONY ROUMO!	nd Smi				2. DATE	OF DEATH		3. TIME OF DEATH		
1	4. SOCIAL SECURITY NUMBER 5		ME (In yrs. lest birthday) VRS.	F UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	(Mon	OF BIRTH th, Day, Year)		BIRTHPLACE (State or Foreign Country)		
FOR	98. FACILITY NAME (H not institution, give stree Anné Arundel Med)	e and number)		96. CITY, TOWN ANDAY	OR LOCATION OF			SC. COUNTY ANNE	of DEATH Arundel		
DIRECTOR	10a. STATE 10b. COUNTY ANY	Arunde		Y, TOWN OR LOCA					10d. INSIDE CITY LIMITS? 1 VES 2 NO		
FUNERAL	100. STREET AND NUMBER 8026 PINC R		1		1. ZIP CODE	a		10g. CITIZEN	OF WHAT COUNTRY?		
ВУ		2. WAS DECEDENT EVE FORCES? 1 VI IF YES, GIVE WAR OF	S 2 NO	If yes, s	CENDENT OF NISC secify Cuban, Mex 1 2 NO Spi	ican, Puerto		ns or No — 14.	RACE — American Indian, Black, White, etc. Specify: White		
COMPLETED	15. DECEDENT'S EDUCAT (Specify only highest grade co. Elementary/Secondary (0-12)	College (1-4 os 5+)	16a. DECEDENT'S (Give kind of Me. Do NOT us	USUAL OCCUPATI work done during m se retired.)	ON ost of working	160	. KIND OF BU	USINESS/INDUS	FRY		
BE COM	17. FATHER'S NAME (First, Middle, Last)	David R. S	Smith	10/11	18. MOTHER'S		Middle, Melde M. Fa				
T0 E	David R. Smith			Pine Rid					yland 21122		
	20a. METHOD OF DISPOSITION 1	ol from State	ROB. PLACE AND DATE (cemetery, crematory or o Metro Crei	ther place)	Inc.			ocation — city altimor	e, Maryland		
	21. SIGNATURE OF FUNERAL SERVICE LICEN	SEE Klone Zu	ognicante ONCE	Georg	NO ADDRESS OF e J. Go Ritchie	nce F			P.A. e, Md. 21225		
	23. PART I. Enter the diseases, or corshock, or heart fellure. Lis IMMEDIATE CAUSE (Final disease or condition resulting in death)	it only one ceuse or	sed the deeth. Do it each line.				diac or reap	piratory arrest	Approximate Interval Between Oneet and Death		
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events Due TO (OR AS A CONSEQUENCE OF): Due TO (OR AS A CONSEQUENCE OF): Due TO (OR AS A CONSEQUENCE OF):										
	resulting in death) LAST d. PART II. Other significant conditions	contributing to death	but not regulting	In the underluke	a sauca ahua	In Part I					
MEDICAL	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO							24b. WERE AUTOPSY FINDINGS: MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO			
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?				LACE OF DEATH	Check only o	ne)				
YSIC	1 Tes 2 DR NO	SPITAL:		OTHER:		_			k		
ву Рн	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	26a. DATE OF INJUR (Month, Day, Yea	r) INJ	M 1	HURY AT DRK? YES 2 NO	28d. DE	SCRIBE HOW	INJURY OCCUR	ED		
	3 Suicide 6 Could not be determined	28e. PLACE OF INJU building, etc. (S	IRY — At home, farm, i pecify)	Y — At home, farm, street, factory, office scify)				28t, LOCATION (Street and Number or Rural Route Number, City or Town, State)			
COMPLETED	29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER:								suse(a) and manner as stated.		
ш	29b. SIGNATURE AND TITLE OF CERTIFIER	A #10			29c. LICENSE N	UMBER	-	29d, DATE SI	GNED (Month, Day, Year)		
TO B	Duzanore Ri	mal fleto	ch. DO		HUZ	73	3	▶ 111	4/95		
	30. NAME AND ADDRESS OF PERSON WHO C	28 lessing	DO CO	e firm	del m	214	2 Ctr				
	31. DATE FILE MONTO-UNB 1995	"SHERETHING	northwelp4								

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31. DATE FILED (Month, Day, Year)
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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the considered for use as the burial-transit permit. Pages 1 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1 be filled within the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
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									9	5 3	13579
3	1 - FOR STATE REGISTRAR	STATE OF MARY	LAND / DEPAR CERTIF				MENT	AL HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Last)						2. DAT	E OF DEATH	AY	YEAR	3. TIME OF DEATH
			MITH				MON	EMBER		1995	5-30 PM
	4. SOCIAL SECURITY NUMBER 212 30 0368		(In yrs. last birthday) 90 YRS.	IF UNDE	DAYS	IF UNDER 24 HRS. HOURS MIN.	(Mor	E OF BIRTH oth, Day, Year)		Country)	
	9a. FACILITY NAME (If not institution, give st		90 THS.	01 017	y Tours	R LOCATION OF I		. 14,			ryland
œ	Harbor Hospita				ltimo		DEATH		9c. COU	NTY OF DE	ATH
DIRECTOR	RESIDENCE OF DECEDENT								14/2	<u> </u>	
12	10e. STATE 10b. COUNTY		I .		OR LOCAT	ION					IOd. INSIDE CITY LIMITS?
		e Arundel		iltir	more						YES 2 X NO
FUNERAL	Hammonds Lane &	lian Nursing	Center		101.	ZIP CODE					AT COUNTRY?
N N	11. MARITAL STATUS	12 WAS DECEDENT EVED	IN II S ADMED	13	WAS DEC	21225 ENDENT OF HISPA	NIC OBIG	IM2 (Specify Vo.		J.S.A.	- American Indian.
BY FI	1 Never Married 2 Married 3 X Widowed 4 Divorced	FORCES? 1 YES	2 XNO		If yes, spe	2 NO Spec	can, Puerto	Rican, etc.)	O NO-	Black, Specify	White, etc.
	15. DECEDENT'S EDUC	CATION	16a. DECEDENT'S	USUAL C	OCCUPATIO	IN	16	Sb. KIND OF BU	SINESS/INC	DUSTRY	WIIICE
E	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind of life. Do NOT u			st of working					
COMPLETED	8th		Superv	rison	r			Hospi	tal		
BE CO	17. FATHER'S NAME (First, Middle, List)	Rubin Jeete	r			18. MOTHER'S N		Middle, Maiden Jorda			
10 B	19e. INFORMANT'S NAME (Type/Print)					nd Number or Rura		mber, City or Tow	n, State, Zip	Code)	
	Revell Jeeter	\	8095	Roun	d Tal	ble Cou	rt	Pasade	na, l	Maryl	and 21122
	20e. METHOD OF DISPOSITION 1 St Burlel 2 Cremation 3 Remo 4 Donation 5 Other (Specify)	oval from State	b. PLACE AND DATE metery, crematory pro Cedar Hil	ther place	sition(Nai	rv	1 1			City or Town	n, Stete Maryland
	21. SIGNATURE OF FUNERAL SERVICE LIC			22.	. NAME AN	D ADDRESS OF F	ACILITY				
	+ Henre me	musufis				e J. Gor Ritchie					
	23. PART I. Enter the diseases, or o	omplications that ceuse	d the deeth. Do i	ot ente	r the mod	de of dying, su	ch sa ce	rdisc or reap	IIIOI	rest.	Approximats
	23. PART I. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdisc or respiratory street, shock, or heart failure. List only one ceuse on each line.								Interval Between Onset and Death		
	diseese or condition resulting in death)	WEZEW.	TERIC	RIC EMBOLISM							48 HOURS
	0		A CONSEQUENCE O								10 11000
8	Sequentisity list conditions,	CHRONI			L	- TISKI	LLA	MOIT			
AT	if sny, lesding to immediate cause. Enter UNDERLYING	DUE TO (OR AS	A CONSEQUENCE O	-):							
RTIFICATION	CAUSE (Disesse or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF):									-	
EH	resulting in death) LAST	1									
0	PART II. Other significent conditions	s contributing to deeth	but not resulting	in the u	nderlying	Cause given is	n Part i	24e. WAS AN	ALITOPRY	24b W	VERE AUTOPSY FINDINGS
MEDICAL	SEPTICEM							PERFOR	MED?		MAILABLE PRIOR TO COMPLETION OF CAUSE
밀								1 TES 2	LIPRO	- 1	F DEATH?
	DID TOBACCO USE CONTR	RIBUTE TO CAUSE (OF DEATH YE	S 🗆	NO D	UNCERTA	IN 🗆			'	L TES Z ESTIO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEA								
VSI	1 TES 2 NO	HOSPITAL:	Ipatient 3 🗆 DOA	OTHE		5 🗆 Residence	8 - Oth	er (Specify)			
H	27. MANNER OF DEATH 1 Netural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)		URY	28c. INJU WOI	RK?	28d. DESCRIBE HOW INJURY OCCURED				
B	2 Accident Investigation	Y — At home, term,	M	1 🗆 Y							
ETED	3 Suicide 8 Could not be determined	building, etc. (Spe	ecify)	Areel, Lac	nory, omice	1	281. LO	CATION (Street a y or Town, State)	ind Number	or Hurel Rou	rte Number,
ة	29a. CERTIFIER (Check only	CIAN: To the best of my know	wiedge, death occurr	d at the	time, data	and place, and du	a to the co	euse(s) and mar	mer as stat	led.	
COMPL		R: On the basis of examination									and manner as stated.
ш	296. SIGNATURE AND TITLE OF CERTIFIER	(P	64-1)			29c. LICENSE NU			29d. DAT	E SIGNED (A	Aorith, Day, Year)
0 B	milion	Ceves				AS 2441	614-	14	PNO	VEMB	ER 03, 1995
	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CALLES OF DE	CATH STEM AT ST.	0.1							

30. NAME AND ADDRESS OF PENSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

SUDHIR KUMAR AGGARNAL, HARBOR HOSTTAL CENTER
DEST. DE MEDICTRE NOVEMBER 03, 1995 BALTIMORE, MD 32. REGISTRAR'S SIGNATURE

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within an incompletely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other transmatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

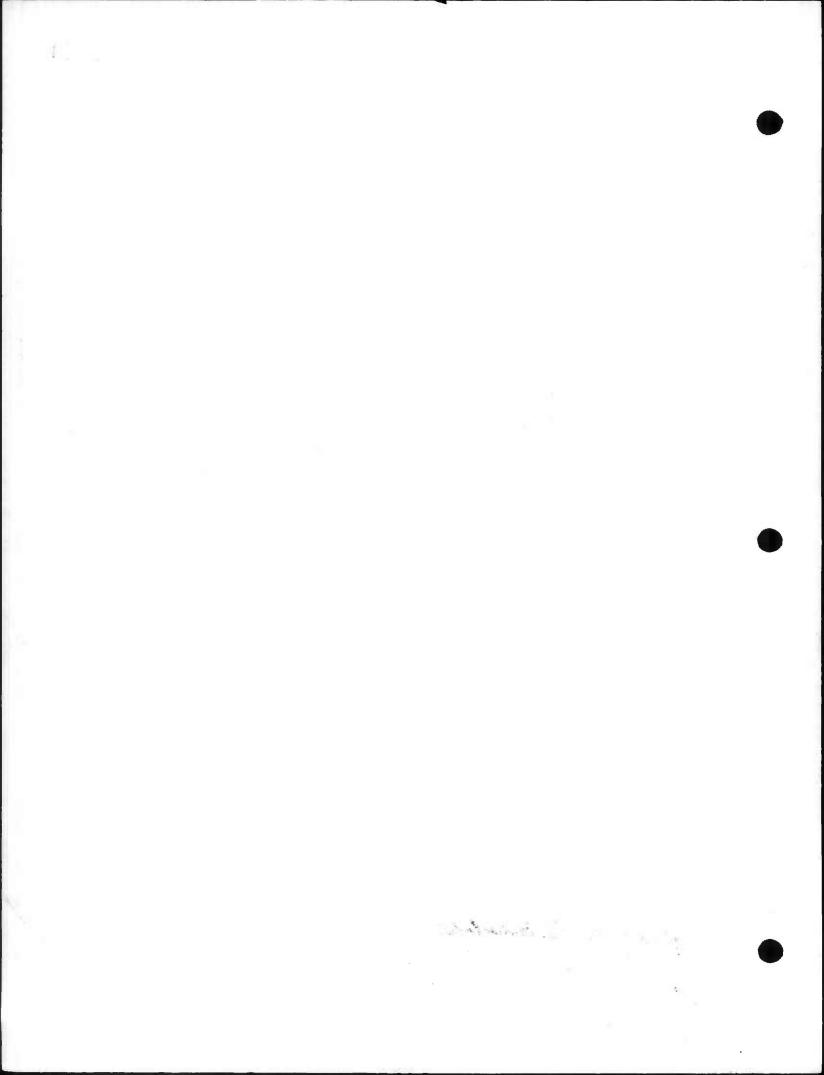
1 - STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

	REGISTRAR		CE	RTIF	ICATE O	F DEATH	REG. NO	D.	
	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF GEATH		3. TIME OF DEATH
	MORRIS STRAM	NGE					ионти	26 1	995 10:37A
		5. SEX	A AOF (1 to-)						
	The second secon		8. AGE (In yrs. last		IF UNDER 1 YEAR		7. DATE OF BIRTH (Month, Day, Year)		8. BIRTHPLACE (State or Foreign Country) SOUTH CAROLINA
		1 X M 2 F	6	9 YRS.			3 13	926	CAROLINA"
1	9e. FACILITY NAME (If not institution, give stre	et and number)			9b. CITY, TOWN	OR LOCATION OF D	EATH	Y-	TY OF DEATH
E E	THE JOHN HOPKIN	IS HOSP	ΤΤΔΤ.		BATTT	MORE, C	ιπν		
I K	RESIDENCE OF DECEDENT	TO HODI	11111		DALLI	TOKE, C.	LLI		
Ä	10a, STATE 10b, COUNTY			10c. CIT	Y, TOWN OR LOC	ATION	-3 1 -3		10d. INSIDE CITY
DIRECTOR	MARYLAND			RAI	LTIMOR	F.			X YES 2 NO
	10e. STREET AND NUMBER			37117		IOT. ZIP CODE		Lacara	EN OF WHAT COUNTRY?
R	1832 W. FAYETTE	Card Bran						10g. CI112	EN OF WHAT COUNTRY?
FUNERAL						21223			
5	1 Never Married 2 Married	12. WAS DECEDENT FORCES? 1	YES 2 NO		13. WAS DI	ECENDENT OF HISPA	NIC ORIGIN? (Specify Years, Puerto Rican, atc.)	n or No-	14. RACE — American Indian, Black, White, atc.
B	3 Wildowed 4 Divorced	3 1F YES, GIVE W	AR OR PATES	46		S 2 NO Specif			0 #
	10		11 2	40	1				BLACK
E	15. DECEDENT'S EDUCA (Specify only highest grade of	TION ompleted)	(GIV	re kind of	Work done during r	TION nost of working	16b. KINO OF BU	JSINESS/INOU	STRY
		College (1-4 or 5 +		Do NOT u	se retired.)				
₽	10TH N	N/A	LA]	BOR			CONSTR	RUCTI	ON
COMPLETED	17. FATNER'S NAME (First, Middle, Lest)					16. MOTHER'S NA	ME (First, Middle, Maide	Sumame)	
BE (UNK.					UNK.			
	19a. INFDRMANT'S NAME (Type/Print)		19b.	MAJLING	ADDRESS /Stree		Route Number, City or To	un State 7in /	Code
5	GENEVA STRANGS					YETTE ST		vii, State, Zip C	200)
	20s. METHOD OF DISPOSITION								
	1 Duriel 2 Cremetion 3 Remov	ral from State	_cemetery, crem	ND DATE	OF DISPOSITION (Name of	DATE 200 L	CATION - C	NGS MILLS, MI
	4 Donation 5 Other (Specify)		5ARRIX	SUN				OMI	NGS MILLS, MD
1	21. SIGNATURE OF TUNERAL SERVICE LICER	NSEE			22. NAME .	AND ADDRESS OF FA	CLTY OLL FUNER	AT II	OME
1	LIP. CANAD	10_							
	23. PART i. Enter the diseases, or con	mplications that	caused the dea	th Do	1 / 1 4	Z W. NUI	CIH AVE.	BALTO	O. MD 21217
	shock, or heart fallure. Li	at only one caus	se on each line.	idii. DO 1	or enter the in	local of dying, suc	in as cardisc or resp	Piratory sire	st, Approximats Interval Between
	IMMEDIATE CAUSE (Final Onset and Dec							Onset and Death	
	disease or condition resulting in death) s. Sep55 DUE TO (OR AS A CONSEQUENCE OF):							2 hours	
1	DUE TO (OR AS A CONSEQUENCE OF):								2
Z	aspiration preumonia 3 days								
CERTIFICATION	Sequentially list conditions, If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):								
5	CAUSE (Disease or Injury								
	that initiated events	DUE TO (OR AS A CONSEQU	UENCE O	F):				
	resulting in death) LAST								
2	DANT II Obber Jestiffen aus mili								
DICAL	PART II. Other aignificant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY PERFORMED?								
	Schemiz cardiday pathy								
W				U					OF DEATH?
	DID TOBACCO USE CONTRI	BUTE TO CAL	ISE OF DEAT	H YE	I ON D	UNCERTAI	NI F		, [150 16] NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL	DOIL TO CA			TH (Check only one		12]		
<u> </u>	EXAMINER?	HOSPITAL:			OTHER:	<u>'</u>			
\Z		☑ Inpetient 2 □				me 5 - Residence			
표	27. MANNER OF OEATH 1 Netural 5 Pending	28a. DATE OF I (Morith, Da		28b. TIM		IJURY AT	28d. DESCRIBE HOW	INJURY OCCU	IRED
84	1 Netural 5 Pending 2 Accident Investigation				M 1 🗆	YES 2 NO			
	3 Suicide 6 Could not be	28s. PLACE OF building, s	INJURY — At hom	ie, farm, :	street, factory, off	lea	281. LOCATION (Street City or Town, State	and Number o	r Rural Route Number,
2	4 Homicide determined		(4,200.,7)				Only or lown, State)	
"	29a. CERTIFIER 1 EXCEPTIEVING PHYSICIA	AN: To the heat of a	mu ka anda da - da -	ab.	oile moisi	V=1/1==0.000 To 1	Land of the land		
COMPLETED							to the cause(s) and ma		
8	A MEDICAL EXAMINENT	On the basis of ac	imination and/or in	ve atigatic	n, in my opinion,	death occured at the	time, data and place, a	nd due to the	cause(s) and manner as stated.
ш	296. SGAATURE AND TITLE OF CERTIFIED	1	- 4-	^		29c. LICENSE NUI	WBER	29d. DATE	SIGNEO (Month, Day, Year)
TO B	Mresson Du	oky	J/7	2		M 60	24.2	Do.	+ 26, 1995
F	30. NAME AND ADDRESS OF ERSON WHO	COMPLETED CAUS	E OF BEATH (ITEM	27) (Туре,	Print)				
	Gregory Proho	powie	2 TAU	ver	110 5	has Hook	ine florit	al Bal	finare MD
	31. DATE FILED (Mooth, Day, Year)	32 REGISTRAF	'S SIGNATURE						
	NUV () 0 1995 Ind.	a diwalan	Tealett -						

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		1 - FOR STATE REGISTRAR	TATE OF MARYLAI		TIMENT OF H		MENTAL HYGIE		
		1. DECEDENT'S NAME (First Middle, Last)	WEIG	YON	Sco	4+	11/ 4	4 95	3. TIME OF DEATH 5: 15 4 M
pinous		4. SOCIAL SECURITY NUMBER 5. S.	1/2 DF 70	yrs. last birthday) YRS.	MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN. OR LOCATION OF DE	7. DATE OF BIRTH (Month, Day, Year)	25 1.	BIRTHPLACE (State or Foreign Country) MARYLAND.
1, 2, 3	DIRECTOR	DLD COULT N		ENFER	RANG	A/B-tow/)	BALH	mule
permit. Pages	1	10e. STATE 10b. COUNTY MALLAN Balti 10e. STREET AND NUMBER	more Co.	10c. CIT	Y, TOWN OR LOCA	A			10d, INSIDE CITY LIMITS? 1 YES 2 NO
155	FUNERAL	5448 Old Court Rd	Apt 101	J.S., ARMED		21133	NIC ORIGIN? (Specify Y	1 11.9	S A
5-0 nding	D BY	3 Widowed 4 Divorced	FORCES? 1 YES	ES	1 TYES	2 [A] NO Specif			Black, White, etc. Specify: BLACK
2 8 8 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	ETE	15. DECEDENT'S EDUCATIO (Specify only highest grade comp Elementary/Secondary (0-12) Co 6th grade	N (leted) 1	(Give kind of ville, Do NOT us	,	ON ast of working	41 20 00	County	y School Svster
YLAND: I by the hospital d be detached to	BE COMPL	17. FATHER'S NAME (First, Middle, Lest) Frank Scott Sr.		CHSLO	шап		ME (First, Middle, Meide		
be retained to 5 should on notified	TO B	190. INFORMANT'S NAME (Type/Print) Dorothea N. Washing	ton	100			Route Number, City or To		/land_21133
E 6 may ector, pa		20a METHOD OF DISPOSITION Burial 2 Cremation 3 Removal 6 4 Donation 5 Other (Specify)		LACE AND DATE	of disposition (Ne ther place) Memoria	eme of al Park	11/10 B	ocation — city altimor	re, Maryland
		21. SIGNATURE OF FUNERAL SERVICE LICENSE	T. Clo	re	1206	W. NORTH			
with hours af with hypetery filled in by cremation, or removent, the medica		23. PART I. Enter the diseases, or compshock, or heart failure. List of IMMEDIATE CAUSE (Finel disease or condition resulting in death)	DUE TO (OR AS A C	in line.	le a	ode of dying, aud	h as cardiac or rea	piretory arreat	Approximata interval Between Onset and Daath
P.O. BOX 68; th certificate be execute ending physician and ci I Hygiene prior to buna or other traumatic	ERTIFICATION	Sequentially list conditiona, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in deeth) LAST	DUE TO (OR AS A C			cel	l defni	phon	~ 2yrs
CORD; ires that the signed by the Health and M ws amy inju	MEDICAL C	PART II. Other algnificent conditions co	e du	200	der		Part I. 24a. WAS A PERFC	ORMED?	24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
AL has b Dept.	CIAN:	DID TOBACCO USE COI 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	SPITAL:	CAUSE OF		ES NC	~		
CLAN:	PHYSICIAN:		Inpetient 2 ER/Outpeti 28e. DATE OF INJURY (Month, Day, Year)	28b, TIM	4 Nursing Hom IE OF 28c. INJ JURY WO		8 Other (Specify) 28d. DESCRIBE HOW	INJURY OCCUR	IED
ISION TTENDING TOR: After after death 28 is ma	TED BY	2 Accident Investigation 3 Suicide 8 Could not be determined	28e. PLACE OF INJURY — building, atc. (Specify	- At home, farm,		YES 2 NO	28f. LOCATION (Stree City or Yown, State	t end Number or (Rurel Route Number,
TAL OR VAL DIRIG	COMPLET	29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On							ause(a) and menner se stated.
TO THE HOSPI TO THE FUNEF be filed within	TO BE C	296. SIGNATURE AND TITLE OF CERTIFIER	ia		18	29c. LICENSE NUI D25//	MBER	29d. DATE SI	IGNED (Month, Day, Year)
_	F	30. NAME AND ADDRESS OF PERSON WHO CO	LETED CAUSE OF DEAT		5310 C	old Co	cert Rd	Ranc	dallslow
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HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within

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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S HAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF OFATH YEAR AUDREY EUNICE SCHILPP Nov. 3, 2:58 PM 1995 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign IF UNDER 24 HRS. 212-12-2666 1 M 2XX 85 Feb. 1910 Maryland 9a. FACILITY HAME (If not institution, give street end number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 526 Alden St., DIRECTOR 21225 Baltimore (Brooklyn Park) Anne Arundel RESIDENCE OF DECEDENT 19c. CITY, TOWN OR LOCATION 10a. STATE 10b. COUNTY 10d. INSIDE CITY Maryland Anne Arundel Baltimore (Brooklyn Park) 1 TYES 2 XNO 10e. STREET AHD HUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 526 Alden Street 21225 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR OATES 13. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Yes or Hoif yes, specify Cuban, Maxican, Puarto Rican, etc.) 14. RACE — American Indian, Black, White, etc. 1 Hever Married 2 Married 1 YES 2X NO Specify: Specify. BY 3 X Widowed 4 Divorced White COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEOENT'S EDUCATION 16b. KIND OF BUSINESS/INOUSTRY (So Elementery/Secondary (0-12) College (1-4 or 5+) Homemaker Housewife and Mother once. 17. FATHER'S NAME (First, Middle, Last)
George Ernest 18. MOTHER'S NAME (First, Middle, Maiden Surname) George 01 ia Linton notified at BE 19a. INFORMANT'S HAME (Type/Print) 2 Ms. Patsy Wood 526 Alden St., Baltimore, Md. 21225 pe 20s. METHOD OF DISPOSITION
1 💢 Buriel 2 🗆 Cremetion 3 🗆 Removal from State 20b. PLACE AHD DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, Stata DATE Mt. Olivet Cemetery 11/7/95 Baltimore, Maryland 4 Donation 5 Other (Specify) 21. SGNATURE OF FUHERAL SERVICE LICENSEE Kevin E. Ecker 22. NAME AND ADDRESS OF FACILITY McCully Funeral Home of Brooklyn 237 E. Patapsco Ave., Balto., Md. 21225 23. PART I. Exter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, abock, or haart fellure. List only one cause on each line. Approximata **Onast and Death** IMMEDIATE CAUSE (Final disease or condition hind OUE TO (OR AS A CONNEGUENCE OF) Vec. resulting in death) event, SINUI LVa CERTIFICATION Sequentially ilst conditions DUE TO JOR AS A CONSEQUENCE OF If any, leading to immediate cause. Enter UNDERLYING enil 5 C CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF) that initiated evanta reaulting in death) LAST 6 injury, PART il. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS MEDICAL AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? any 20 1 TYES 2 NO shows a 1 TYES 2 1 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO WINCERTAIN IN PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Item OTHER 1 YES 2 NO 1 Inpatient 2 P ER/Outpatient 3 P DOA ng Home 5 Diffeeldence 10 27. MANNER OF DEATH 28a, DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked, 1 A Hatural IHJURY 5 Pending 14 1 YES 2 NO BY 2 Accident Investigation 3 Sulcide 28s. PLACE OF INJURY — At home, ferm, street, factory, office building, stc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28 is 8 Could not be determined O THE FUNERAL DIRECTOR.
TO THE FUNERAL DIRECTOR.
De filed within 72 hours after COMPLET 29a, CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. MEDICAL EXAMINER: On the basic of examin occured at the time, date and place, and due to the cause(s) and manner as stated. TITLE OF CERTIFER LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 3/1 6 November 1995 2

PLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32 REGISTRAR'S

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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle Last) 3. TIME OF DEATH 2. DATE OF DEATH AMES 1/ 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. a. BIRTHPLACE (State or Foreign 2/8--5604 72 TU4V23 permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR ERIDIAN N LOCH BALTIMORE DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MOKE 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 6407 2/206 n and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit to burial, cremation, or removal. U.S.A retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-AND 21215-0020 14. RACE -- American Indian, Black, White, etc. If yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: Never Married 2 Married BY wed 4 Divorced COMPLETED 18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 18b. KIND OF BUSINESS/INDUSTRY College (1-4 or 5+) PAINTENANCE ATIONAL BREW. Once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First Middle notified at BE 19a. INFORMANT'S NAME (Type/Print) 2 EDITH BAIL 2 pe 20e.METHOD OF DISPOSITION

1 | Burlel 2 | Cremation 3 | Removal from State
4 | Donetion 5 | Other (Specify) hours after death. Page 6 may must 20b. PLACE AND DATE OF DISPOSITION // OATE 20c. LOCATION examiner 21. SIGNATURE OF PUNERAL SERVICE LICENSEE the medical 23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata shock, or heart fallure. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Final Onset and Death disease or condition Frterioscleste cornery artery desease event, resulting in death) DUE TO (OR AS A CONSEQUENCE OF executed traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate been signed by the attending physician it. of Health and Mental Hygiene prior to certificate be cause. Enter UNDERLYING CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF) that initiated events reaulting in death) LAST 9 requires that the death Inlury. DIVISION OF VITAL RECORDS PART ii. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. PHYSICIAN: MEDICAL 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? shows any 1 YES 2 NO OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\Boxed{1}\) NO \(\Boxed{1}\) UNCERTAIN \(\Boxed{2}\) has by Dept. HOSPITAL OR ATTENDING PHYSICIAN: The law 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) ltem! After this certificate death with the State HOSPITAL OTHER: 1 YES 2 NO 1 - Inpatient 2 - ER/Outpatient 3 - DOA 4 S Nursing Home 5 Residence 8 Other (Specify) 0 28a. OATE OF INJURY (Month, Day, Year) 27, MANNER OF DEATH 28b. TIME OF 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED marked. 1 Natural 1 YES 2 NO BY 2 Accident 26s. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) 3 Suicide 99 281. LOCATION (Street and Number or Flural Floute Number, City or Town, State) COMPLETED 6 Could not be DIRECTOR: hours after 500 4 Homicide Item 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. TO THE HOSPITAL TO THE FUNERAL C be filed within 72 h 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c, LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE Novan miller 121022 MI) 0 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Kong LENSICI 8604 IT ARPORA ALTU. MD 21234

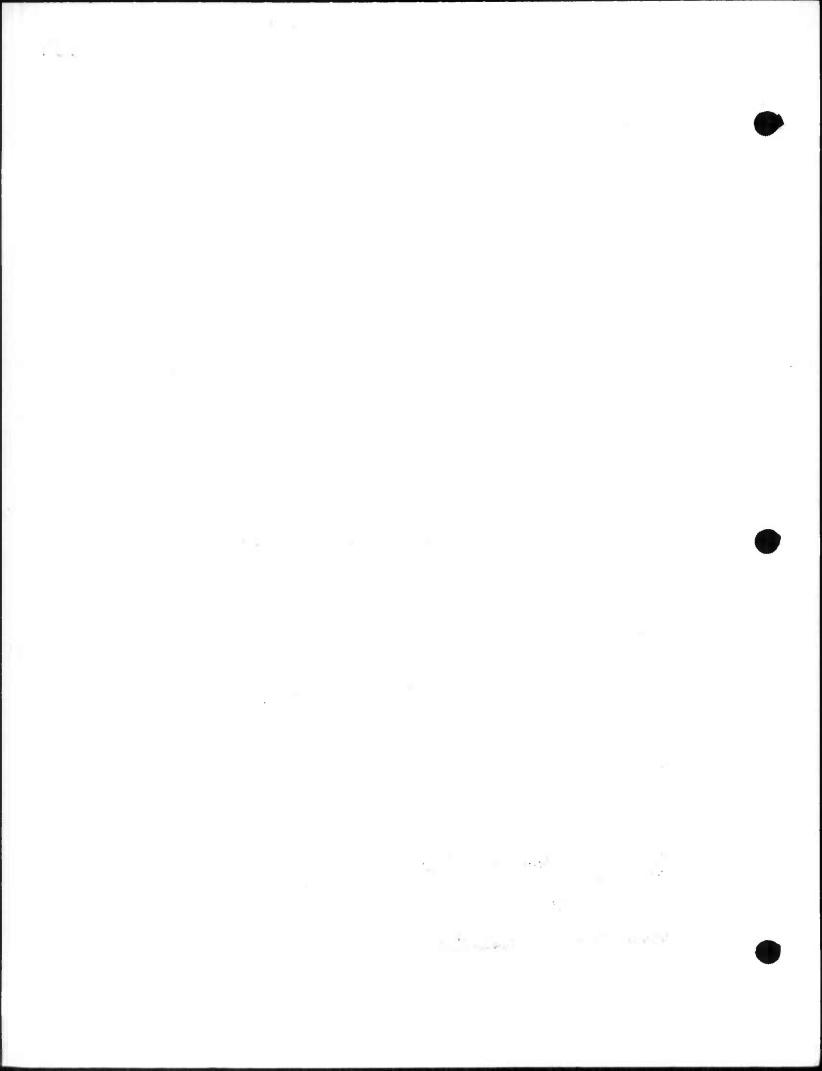
31. DATE FILEO (Month, Day, Year) NOV 0 8 1995

32. REGISTRAR'S SIGNATURE

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, MARYLAN	
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DIVISION OF VITAL RECORDS, P.

	1 - FOR STATE REGISTRAR	STATE OF MARYL		IT OF HEALTH AND	MENTAL HYGIEN					
	1. DECEDENT'S NAME (First, Middle, Last)	SOME	RVILLE		2. DATE OF DEATN	MY 197	3. TIME OF DEATH			
	4. SOCIAL SECURITY NUMBER			ER 1 YEAR IF UNDER 24 HRS.	7. DATE OF BIRTH	0.	BIRTNPLACE (State or Foreign			
	238-56-1747 So. FACILITY NAME (If not institution, give str	1 M 2 D F	95 YRS. MONTH		MARCH 15,	1900 W	PARKEN CO, N.C.			
DIRECTOR	40/8 EMMART	AVE.	96. G	BATIMORE	DEATH /	BC. COUNTY	OF DEATH			
JEC.	10a. STATE 10b. COUNTY	. /	10c. CITY, TOWN	OR LOCATION		/	10d. INSIDE CITY			
- 1	MD.	N/A	BALT	MORE			1 YES 2 NO			
FUNERAL	100. STREET AND NUMBER 4018 EMMART	- 1110	4	10f. ZIP CODE			OF WHAT COUNTRY?			
	11. MARITAL STATUS	12. WAS DECEDENT EVER I	N U.S. ARMED 1	2/2/6 . WAS DECENDENT OF NISP	NIC ORIGIN? (Specify Ve		SACE - American Indian			
BY F	1 Never Married 2 Merried 3 Wildowed 4 Divorced	FORCES? 1 YES	2 NO	If yes, specify Cuben, Maxie 1 YES 2 NO Spec	an, Puerto Rican, etc.)		RACE — American Indian, Black, White, etc. Specify: IRI ACK			
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade of	ATION completed)	18e. DECEDENT'S USUAL (Give kind of work don	e during most of working	CUPATION 18b. KIND OF BUSINESS/INDUSTRY					
PLE	Elementary/Secondary (0-12)	College (1-4 or 5+)	FARMER	le retired.)						
Š N	17. FATHER'S NAME (First, Middle, Lest)	0	7///-/-	18. MOTNER'S N	AME (First, Middle, Maider					
BE	ROBERT	DOMERVIL		- //		NKNOW				
2	19a. INFORMANT'S NAME (Type/Print)	21111	19b. MAILING ADDRE	SS (Street end Number or Rura						
	ROGER SOME		4018 E		E. PALT	CATION - City	MD. 21216			
	1 Burlal 2 Cremetion 3 Ramo	val from State Cer	PLACE AND DATE OF DISP Pelery, cremetory or other please PE GROVI	ni A		0.4	or Town, Stata			
	21. SIGNATURE OF FUNERAL SERVICE LICE			. NAME AND ADDRESS OF F	ACHLITY					
	I Lhomas &	Skard	ah.	SKARDA F.H	1. 2829 1. BALTO	·· Mb	21224			
	23. PART I. Enter the diacesea, or canada ahock, or haart feliure. L	omplications that cause list only one cause on a	d the death. Do not ente	er the mode of dying, su	ch as cardisc or resp	iratory arreat,	Approximata Interval Between			
	IMMEDIATE CAUSE (Final disease or condition resulting in death)	Possible	MYOCA	ROIAL IN	FARETTON	1	Onset and Death			
	Sequentially list conditions, If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):									
RTIFICATION										
3	cause. Enter UNDERLYING CAUSE (Disease or Injury									
	that initiated eventa DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST									
CER	d						A.			
A.	PART II, Other aignificant conditions	contributing to death t	out not reaulting in the	inderlying cause given in	Part I. 24s. WAS AN	AUTOPSY	24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO			
EDIC	MAILKINSONO	My PECES	1 67 82	EEDING AS	NTIE 1□ YES :	NO	COMPLETION OF CAUSE OF DEATH?			
Σ∥	Stevons if	EAGDRAFION	, DECUBI	THE ULCER			1 TES 2 NO			
AN	DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL	IBUTE TO CAUSE C			N 🗆 📗					
2	25. WAS CASE REFERRED TO MEDICAL EXAMMER? 1 YES 2 NO 1 Inputlent 2 ER/Outpatlent 3 DOA 28. PLACE OF DEATN (Check only one) OTHER: 4 Nursing Nome 5 Realdence 8 Other (Specify)									
PHYSICIAN:	27. MANNER OF DEATN	28a, DATE OF INJURY	28b. TIME OF	28c. INJURY AT	8 U Other (Specify) 28d. DESCRIBE NOW	INJURY OCCURE	D .			
2	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJURY	WORK? 1 YES 2 NO						
COMPLETED	3 Suicide 8 Could not be 4 Nomicide determined	28e. PLACE OF INJURY building, etc. (Spe	— At home, ferm, street, le	ctory, office	281. LOCATION (Street end Number or Rural Route Number, City or Town, Stete)					
ן נ	290. CERTIFIER 1 CERTIFYING PHYSIC	IAN: To the best of my know	ledge death occurred at the	time, date end place, end du	to the source(e) and me					
2				opinion, death occured at th			use(e) and manner as stated.			
	296. SIGNATURE AND TITLE OF CERTIFIER	4								
	290. DATE STURED (MORITI, DB), ROBEL									
	Alther	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Pring) SO STATES HICROSTANI SO								
0 0	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DE	ATH (ITEM 27) (Type, Print)	- 1)		EPH R	RUATTANI			
	30. NAME AND ADDRESS OF PERSON WHO 31. DATE FILED (Month, Day, Year) NOV 0 8 1995	COMPLETED CAUSE OF DE	Rel BA	- 1)		EpH le	8/-55 RBATTANI MO			

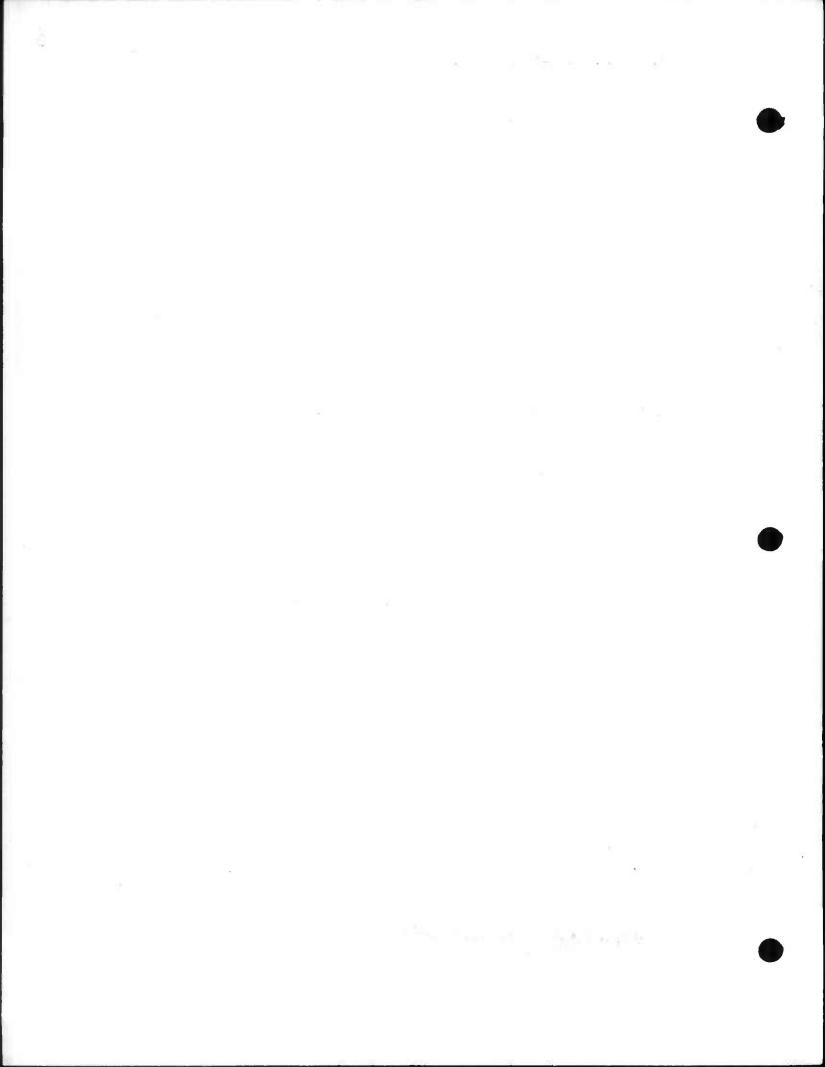


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Page 6 may be retained by the hospital or attending physician. TO THE HOSPITAL OR ATTENDING PHYSICIAN: The

STATE OF MAR	YLAND / DEPARTMENT	OF HEALTH	AND MENTAL	HYGIENE
	CERTIFICATE	OF DEAT	ГН	REG NO

		REGISTRAR		CEI	RIIFICA	ATE O	F DEATH		REG. NO.			
		1. DECEDENT'S NAME (First, Middle, Last)						2. DATE (F DEATH		3.	TIME OF OEATN
		Elizabeth	PRITCHARD	Sel	nlh	005	5+	NO		190	EAR C	C: UCA M
		4. SOCIAL SECURITY NUMBER		E (In yrs. lest t	birthday) IF t	INDER I YEA	II IF UNDER 24 HRS.	7. DATE C	F BIRTH			ACE (State or Foreign
		212-05-2495	1 🗆 M 2 🗗 F	80	YRS. MON	THE DAY	B HOURS MIN.		Day. Year)		Country)	yland
3 should		Sa. FACILITY NAME (If not institution, give s	treet and number)		9b.	CITY, TOW	N OR LOCATION OF DE		1, 17.	9c. COUNTY		-
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6,	СТОВ	RESIDENCE OF DECEDENT				Ба	ITTIMOTE			λ.	1/a	
Sec	Ĭ,	10a, STATE 10b, COUNTY	Y		10c. CITY, TO	WN OR LO	CATION				10	d. INSIDE CITY
T.	DIRE	Maryland Bal	timore		Lı	ither	ville				1.1	LIMITS?
E .		10e. STREET AND NUMBER	5 I M O I C			T	101. ZIP COOE			10a CITIZEI		T COUNTRY?
the bunal-transit permit. Pages 1,	RAL	1333 Broadway Ro	and				2109	2			ISA	COUNTRY
tran	FUNE	11. MARITAL STATUS										
ruin de la la la la la la la la la la la la la	F	1 Never Married 2 X Married	12. WAS OECEOENT EVER FORCES? 1 YE	S 2 X NO	ED	13. WAS D	DECENDENT OF HISPAN specify Cuban, Mexica	IIC ORIGIN? n, Puerto Ri	(Specify Yes can, etc.)	or No- 14	Black, W	American Indian, hite, etc.
9	B	3 Widowed 4 Divorced	IF YES, GIVE WAR OR	OATES		1 🗆 Y	ES 2 X NO Specify	<i>r</i> :			Specify:	White
SS	۵	15. DECEDENT'S EDUC	CATION	I see DECE	DENT'S USU	AL OCCUPA	7104	T 401				WILLE
asn	쁘	(Specify only highest grade	completed)	(G/ve		done during	most of working	160.	KIND OF BUS	INESS/INDUS	THY	
D P	OMPLET	Elementary/Secondary (0-12)	College (1-4 or 5+)					- 1	0	77		
detache Once.	Σ	17. FATNER'S NAME (First, Middle, Last)		Н	omemal	ker				wn Hon	ie	
be de	8			n			18. MOTNER'S NA		3.07			
9 9	띪	unknown by info	rmant .	Pittma			Susie		Prit			
5 should notified		18a. INFORMANT'S NAME (Type/Print)					et and Number or Rural I					21221
age 5		Ronald L. Maher		30	5 W. (Chesa	peake Ave	, Tow	son,	Maryla	nd	21204
ed .		20e. METHOD OF DISPOSITION 1 N Buriel 2 Cremation 3 Removed		tob. PLACE AN			(Name of	BATE	20c. LOC	ATION — City	or Town,	State
must		4 🗍 Donation 5 🗆 Other (Specify)			n Parl		netery	Nov		ltimor	e. M	aryland
tuneral di I. examiner		21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY										
fune	ı	Lemmon Funeral Home 10 W. Padonia Rd., Timonium, MD 21093										
signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use Health and Mental Hygiene prior to burial, cremation, or removal. ws any injury, or other traumatic event, the medical examiner must be notified at once.	-					10	W. Padon	ia Ro	., Ti	monium	ı, MD	21093
		23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, another, or heart failure. List only one cause on each line. Approximate interval Between										
n. o		IMMEDIATE CAUSE (Fine)										
nation.		disease or condition Sueast (anav - Metastatic										
crei			DUE TO (OR AS	A CONSEOU	ENCE OF):		- VOCE	C 010				
sician and complete prior to burial. crema traumatic event,	z		b.									
to t	CERTIFICATION	Sequentially list conditions, if any, leading to immediate										
prior tra	8	CAUSE (Disesse or Injury										
ing phy giene p	드	that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST										
Hyg or o	ᇤ	d,										
y the att nd Menta injury,		DARW II On a standing of the										
nd A	EDICAL	PART II: Other significent condition	1	/	_		ring ceuse given in	Part I.	PERFORI			RE AUTOPSY FINDINGS VILABLE PRIOR TO
ith an	음	Terminal CI	nrome e	ma	y Sen	ra			1 YES 2		CO	MPLETION OF CAUSE DEATH?
	ME			V	į.				,			YES 2 NO
pt. of P	AN:	DID TOBACCO USE CONTI	RIBUTE TO CAUSE	OF DEATH	H YES [] NO	UNCERTAIN	1 🗆				
OIRECTOR: After this certificate has been hours after death with the State Dept. of item 28 is marked, or item 23 sho	M	25. WAS CASE REFERRED TO MEDICAL			OF DEATH (C							
State Item	SICI	EXAMINER? 1 YES 2 YOO	HOSPITAL: 1 Inpetiant 2 ER/O	utostlant 3		HER:	ome 5 🗆 Rasidence	e 🗆 an	(0			
the the	H	27. MANNER OF DEATH	28a. DATE OF INJUR	- T	28b. TIME OF		INJURY AT			JURY OCCUR	ED	
fter this c eath with marked,	۵	1 Natural 5 Pending	(Month, Day, Year)	INJURY	'	WORK?	200.000	WIDE NOW III	JONI OCCUP	EU	
After death	ВУ	2 Accident Investigation	26e. PLACE OF INJU	DV At home	form atreat							
after d	ED	3 Suicide 8 Could not be 4 Homicide determined	building, atc. (S)	pecify)	r, mrm, street,	, ractory, or	rrice	City or	Town, State)	nd Number or i	Rural Routs	Number,
OIRECTOR: hours after item 28 i	PLET											
AL OIRE 72 hours 11 item	됩		CIAN: To the best of my kno									
FUNERAL within 72 P	COM	2 MEDICAL EXAMINE	R: On the beals of examinat	tion and/or inv	estigation, in	my opinion	i, death occured at the	time, deta s	nd place, and	due to the c	ause(a) an	d manner as stated.
TO THE FUNERA be filed within 7 IMPORTANT:		29h. SIGNATURE AND TITLE OF CENTIFIER	1				29c. LICENSE NUM	BER		29rl DATE SI	GNED (Mo	onth, Day, Ybar)
五 6	BE	1/05/1	(MM)				0222	74	- 1	D Lla	(N)	055
F 2 €	2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF	DEATH IITEM	7) (Type Doyne	1	10/13	> 7		7/0	01/	-/ //
	4	The policy	12V2115	5 /	111	70	00 11 4	2- (1 n	014	5	12/1
	- 1	31. DATE PILED (Month, Day, Year)	120 ECIOTE ADIO	and ATTIME	VVV	702	OWY	0 7	V /2	axi	(1011
	-	NOV 0 81995	Java Waute	or hard	4							,
- 1		100 0 0 1232	Man and									



	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit nermit. Pages 1 2 3 should	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.			TO THE FUNCTION AT LEMBING PRINCIPATION IN the Average of the properties that the properties of the properties of the properties of the properties of the properties of the properties of the attending physician and completely filled in by the function, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL	HYGIENE
R	CERTIFICATE OF DEATH	REG. NO.

	1 - STATE REGISTRAR	STATE OF MARYLAN	D / DEPARTI	MENT OF H	EALTH AND	MENTAL HYGI				
	1. DECEDENT'S HAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH		
	CASTILE		TO	LES		NOVEMBER	1. 1995			
	100 110 11 n A	1 - M 2 PF 44	YRS.	ONTHS DAYS	F UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year	1947	HATHPLACE (State or Foreign outry)		
TOR	THE JOHNS HOPKI				RE CITY	EATH	9c. COUNTY	OF DEATHY		
DIRECTOR	10a. STATE 10b. COUNTY	V/A	10c. CITY, 1	PALTIN	ORE		on.	10d. INSIDE OITY LIMITS? 1 A YES 2 NO		
FUNERAL	100. STREET AND NUMBER A 100	TT CT		101	2120	72	10g. CITIZEN	OF WHAT COUNTRY?		
BY FU	11. MARITAL STATU 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER IN U.S FORCES? 1 ☐ YES 2 IF YES, GIVE WAR OR DATES	NO	If yes, sp	EHDENT OF HISPA city Cuban, Maxico 2 D NO Specia	NIC ORIGIN? (Specify an, Puerto Rican, etc.) (y:		RACE — American Indian, Black, White, etc. Specify:		
	15. DECEDENT'S EDUCA	TIOH 166	. DECEDENT'S US	UAL OCCUPATION	N	16b, KIND OF	BUSINESS/INDUSTI	LACK		
COMPLETED	(Specify only highest grade co	College (1-4 or 5+)	(Give kind of word life. Do NOT use in	done during mo		PRIVATE				
ğ	17. FATHER'S NAME (First, Middle, Last))	/		18. MOTHER'S N	ME (First, Middle, Maid	ien Sumame)			
BE (MENRY MILL	-5			Kub	V ATA	m			
10	184. INFORMANT'S NAME (Type/Print) PUGENE MI	45	196. MAILING AC	WES	TERN R	Route Number, City or	Fown, State, Zip Cook	D. 21209		
	209. METHOD OF DISPOSITION 1 We Buriel 2 Cremiston 3 Remove		CEAND DATE OF		me of	OFTE 20c.	LOCATION - City	or Town, State		
	4 Donation 6 Other (Specify)	11/1	1,40	1/ Ch	n_{-}/l_{\perp}	18/95 4	WSDOW	NB_MY,		
	21. SIGNATURE OF THE HALL SERVICE LICEN		and the second second	3012	Tanks	WITTEN	5RA/190	ME PIA		
	23. PART 1 Enter the diseases, or con	mplications that caused the	e desth. Do not	enter the mo	de of dying, suc	ch sa cardiec or re	spiratory arrest,	Approximats		
	IMMEDIATE CAUSE (Final disease or condition English of Cause on a ach line.									
ľ	resulting in death) a.	DUE TO (OR AS A CO						, ments,		
z		Intravenou	5 Dr	ng (re			5 years		
5	Sequentisity list conditions, if any, issding to immediate	DUE TO (OR AS A CO	HSEOUEHCE OF):							
CERTIFICATION	CAUSE (Disease or injury									
Ē	that initiated events DUE TO (OR AS A COHSEQUENCE OF): resulting in death) LAST									
E	d.									
PHYSICIAN: MEDICAL	PERFORMED? 1 YES 2 5 NO OF OR							24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF OEATH?		
≥	DID TOBACCO USE CONTRIL	BUTE TO CAUSE OF D	FATH YES		LINCEDTAIL	N D		1 TYES 2X NO		
A	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO SUNCERTAIN 126. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one)									
Sic		HOSPITAL:		THER:	5 Residence	6 Other (Specify)				
	27. MANHER OF DEATH	26a. DATE OF IHJURY (Month, Day, Year)	26b. TIME O	F 28c. IHJ	JRY AT	28d. DESCRIBE HO	W INJURY OCCURE	D		
ВУ	1 Hetural 5 Pending 2 Accident Investigation	(WORLE, Day, 1941)	INJUN		ES 2 HO					
	3 Suicide 6 Could not be determined	28e PLACE OF IN ILIDY — At home form street feeten office								
٦ ا	29a. CERTIFIER 1 CERTIFYING PHYSICIA	AH: To the best of my knowledge	, death occurred a	t the time date	and place, and due	to the councie) and				
COMPLETED	2 MEDICAL EXAMINER:	On the basis of examination and						se(a) and menner as stated.		
H	Noal Leutin, MD	Medicine 1	Resident		M631			HED (Month, Day, Year)		
임	30. HAME AHO AODRESS OF PERSON WHO	COMPLETED CAUSE OF DEATH	(ITEM 27) (Type, Pri	nt)						
	Noah Lechtzin, Joh	nas Hepkins Ho	spital, To	ower 11	o, Balt.	more, Me	ryland	21287		
	NOV 0 8 1995 Jahr	32 REGISTRAR'S DIGHATUR	RE .	<u></u>						

Later Inc.

192 (G.E) TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

em10c,g-/29,1	1-8-95,pert.h.,dk				
R	STATE OF MARYLAND	/ DEPARTMENT (OF HEALTH AND	MENTAL	HYGIENE
CICTRAD	•	EDTIELCATE .	OF DEATH		

- 2	/2 Item10c,g-729,11-8-95,	perf.h.,dk						93) 333	01
	1 STATE	STATE OF MARYLAND I				MENTAL				
	REGISTRAR 1. DECEDENT'S NAME (First, Middle, Lest)		ERIIF	ICATE OF	DEATH	2. DATE C	REG. NO.		3. TIME OF DE	AVU
	GARRETT		rows	,		OCT	. 31 ^w	1995	5:34	Р. м
	nam panalil	SEX 6. AGE (In yrs. la	st birthday) YRS.	MONTHS DAYS	HOURS MIN.		E OF BIRTH sth, Day, Year) 2.1900 NA		ARY MA	Foreign
_	9e. FACILITY NAME (If not institution, give street	end number)		9b. CITY, TOWN	OR LOCATION OF DI	EATH		9c. COUNTY C	OF DEATH	-
DIRECTOR	1301 LUZERINE A	AVE.		BALT	IMORE	100		/V	14	
E	10e. STATE 10b. COUNTY		10c, CIT	Y, TOWN OR LOCA	TION			_	10d. INSIDE C	ITY
	MD. BAH	IMORE	1-1-	LANTAL	LHOWN	Sev	ern		1 TYES 2	MO
FUNERAL	8200 AUTUMA	1 LAXE C	Ti	10	2114.	4		10g. CITIZEN	S HAT COUNTRY	7
N		. WAS DECEDENT EVER IN U.S. AFFORCES? 1 YES 2			ENDENT OF HISPAI			or No- 14. F	RACE — American Ir Black, White, etc.	ndien,
BY	1 Never Merried 2 Merried 3 Widowed 4 Divorced	IF YES, GIVE WAR OR DATES		1 TYES	2 NO Specif		curi, esc.)	F	FLACK	
TED	15. DECEDENT'S EDUCATION (Specify only highest grade com	npleted) ((WORL OCCUPATE		-	1000	INESS/INDUSTR	₹Y	
COMPLET	Elementary/Secondary (8-12) C	College (1-4 or 5 +)	ONG	PRUCTI	an		Built	PING		
BE CO	17. FATNER'S NAME (First, Middle, Last)				18. MOTHER'S NA	WE (First, M	15_	MNE	R9	
TO B	DON WATS	19	320	ADDRESS (Street	and Number or Rural	Ploute Number	or, City or Rawn	Rhoda	1214	14 10.
	24 METNOD OF DISPOSITION 1 Burlet 2 Cregitton 3 Removal 4 Donation 5 Oner (Specify)	from State 20b. PLACE		OF DISPOSITION (N.	ame of	1-1/4	200 LO	CATION — City	or Town, State	277
	21. SIGNATURE OF PANERAL SERVICE LICENS	4/		22. A ME A	ND ABOTESS OF	HIT / E	Tune	2nl	Home V	h
	* Van N M	land	Salah Pa	270	FOUNDA	1700	Par	a Bat	T WAD A	200
	23. PARLY, Enter the Diseases, or com	plications that ceused the d	eath. Do	not enter the mo	ode of dying, suc	h sa card	ac or reapi	ratory arrest,	Approx	
	IMMEDIATE CAUSE (Finel	only one cause on each lin								Between and Death
	disease or condition resulting in death) s	Gun Shot	Wou	end to	, bac	K				
		DUE TO (OR AS A CONSE	EOUENCE O	PF):						
ERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A CONSE	OUENCE O	PF):					-	
S	cause. Enter UNDERLYING CAUSE (Disease or Injury									
E	that initiated events resulting in deeth) LAST	DUE TO (OR AS A CONSE	OUENCE O	PF):						
CER	d									
AL	PART II. Other significant conditions co	ontributing to death but not	resulting	in the underlyin	g cause given in	Part I.	24s. WAS AN		24b. WERE AUTOPS	
8			t Performed COMPLETION OF CAUSE OF DEATH?							
M	DID TORACCO HEE CONTRIBUTE TO CAUSE OF DEATH. VES TI MO TI HANCEDTAIN TI									NO
IAN	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATN (Check only one)									
Sic		OSPITAL: Inpatient 2 ER/Outpatient	3 🗆 DOA	OTHER:	ne 5 🗆 Reeldence	a Xother	(Specify) (ON STE	REET	
PHYSICIAN: MEDICAL	27. MANNER OF DEATN	28a. DATE OF INJURY 28b. TIME OF 28c. INJURY AT 28d. DESCRIBE NOW INJURY OCCURED INJURY WORK?								
B	2 Accident Investigation	atural 5 Pending 10-31-95 1700 M 1 YES 2 7 NO Subject								
	3 Suicide a Could not be determined	28e. PLACE OF INJURY — At h building, etc. (Specify)		street, tactory, one	:0		r Town, State)	nd Number of Pl 2erhe	St- Bru	Ulmare
COMPLETED	29e. CERTIFIER 1 CERTIFYING PNYSICIAN	N: To the best of my knowledge, d	-	red at the time date	end place, and dur				1. 1.00	umare
PA	ana)	on the basis of examination end/or							use(e) end menner e	e stated.
	29b. SIGNATURE AND TIFLE OF CERTIFIER	12/1			29c. LICENSE NU			29d. DATE SIG	INED (Month, Day, Ye	ar)
TO BE		49 4L			O.C.M	I.E.		▶ NOV	7. 1, 19	995
۲	30. NAME AND ADDRESS OF PERSON WHO CO	_ /			reet, E	Balti	more	, Mary	land 2	1201
	31. DATE FILE NOWY 040 148 1995	3 Special and the section of the	ardall							

BALTIMORE, MARYLAND 21215-0020

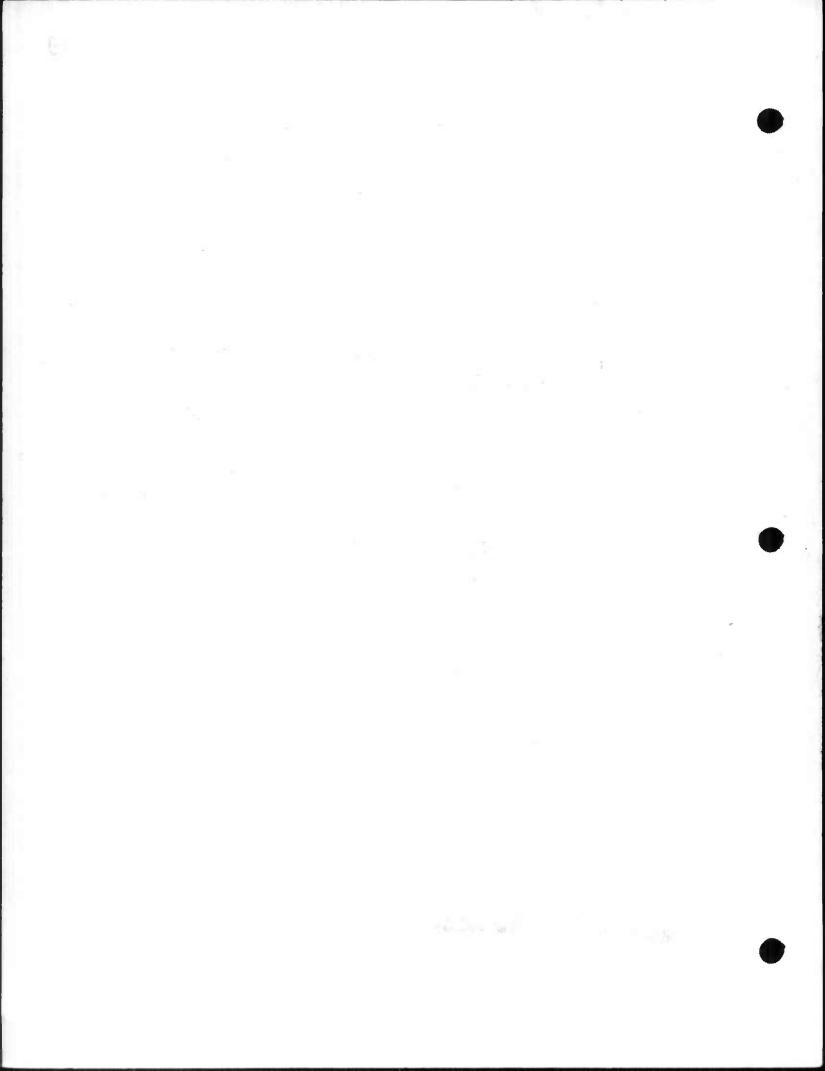
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	FOR 1 - STATE REGISTRAR	STATE OF MARYLAND		TOF HEALTH AND	MENTA	L HYGIENE REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Lest)	Verdi			2, DATE MONT	OF DEATH DAY	year 7 4 M		
	4. SOCIAL SECURITY NUMBER 048-18-5463	5. SEX 1 M 2 D F 69	YRS. MONTH		JUA	UE 3:1926	BROOKLYN, N.Y.		
TOR	98. FACILITY NAME (If not institution, give s WAYSON MOBIL RESIDENCE OF DECEDENT	ECT. LoT 52	β 9b. Ci	LOTHIAM		9c. COUNT	A.Co		
DIRECTOR	MD - 10b. COUNTY	A - A - Co	10c. CITY, TOWN	OTHIAN			10d. INSIDE CITY LIMITS? 1 YES 2 NO		
FUNERAL	WAYSON MOBIL		52	101. ZIP CODE 207//	i	U	S.A.		
BY	11. MARITAL STATUS 1 Never Married 2 Married 3 Nidowed 4 Divorced	12. WAS DECEDENT EVER IN U.S. A FORCES? 1 XYES 2 I IF YES, GIVE WAR OR DATES	ARMED 1	3. WAS DECENDENT OF HISPA If yes, specify Cuben, Maxic 1 YES 2 NO Spec	an, Puerto		4. RACE — American Indian, Black, White, etc. Specify: / TE		
LETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	CATION 16e. (DECEDENT'S USUAL (Give kind of work doi life. Do NOT use retired	e during most of working	168	b. KIND OF BUSINESS/INDU	STRY		
COMPLET	17. FATHER'S NAME (First, Middle, Last)	(20)	CHRPE	18. MOTHER'S N	AME (First,	Middle, Meiden Surname)	111		
TO BE	19a. INFORMANT'S NAME (Type/Print)	LEADI LEADI	1 4	SS (Street and Number or Rura MOBILE CT	_	ober, City or Town, State, Zip C	AN, MD. 20111		
	20 METHOD OF DISPOSITION 1 Buriel 2 Cremation 3 Rem 4 Donation 8 Other (Specify)		EAND DATE OF DISP		DAT 1-8-95	TE 20c. LOCATION - CI	ty or Town, State CELLO, D.Y.		
	21. SIGNATURE OF SUNERAL SERVICE LIE	- Starle	1.	SKANDA F.H.	DA	29 HUDSON			
	23. PART i. Enter the diseases, of shock, or heart feilure. IMMEDIATE CAUSE (Finel disease or condition resulting in death)	List only one ceuse on each lie a. Meta Static DUE TO (OR AS A CONS	So ua				Approximate interval Between Onset and Death		
CERTIFICATION	Sequentisity list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								
AL.	PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO OF DEATH?								
PHYSICIAN: MEDIC	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN								
YSICI/	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPITAL: 1 Inpetient 2 ER/Outpatient	ACE OF DEATH (Che		8 🗆 Oth	er (Specify)			
ву Рн	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	JER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 29c. INJURY AT WORK? M 1 YES 2 NO							
	3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF INJURY — At building, etc. (Specify)	home, term, street, t	ectory, office		CATION (Street and Number of y or Town, State)	r Rural Route Number,		
COMPLETED	onel	ICIAN: To the best of my knowledge, ER: On the beels of examination and/o							
BE	29b. SIGNATURE AND TITLE OF CENTIFIES	(marchine	_ Mi	29c. LICENSE N	UMBER 33	(_23 ► //	SIGNED (Monty), Day, Year)		
10	30. NAME AND ADDRESS OF PERSON WH	10 COMPLETED CAUSE OF DEATH (17		WILLIAN	n	=, UMH A	a'U'mD		
	31. DATE FILED (MON'S 1995	1 hours		D WITINGS	1 7 1		5		

DIVISION OF VITAL RECORDS, P.O. BOX 68760

ned by the hospital or attending physician. build be detached for use as the burlal-transit permit. Pages 1, 2, 3 should	led at once.	TO BE COMPLETED BY FUNERAL DIRECTOR	9a. 10a. Mic 10a. 11. 8 1
ath. Page 6 may be retain ineral director, page 5 shor	aminer must be notifi	10	20a. 1 X 4 =
THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlal-bransit permit. Pages 1, 2, 3 should filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlal, cremation, or removal.	IFURIAN: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION	23. IMA distress Second from CAL that rest PAF 25. V 1 27. M 1 2 3 4 29a.
표를	2	8	4 90.

						9	5 3	3589		
FOR STATE REGISTRAR	STATE OF MARY		TMENT OF H		MENTAL HYGI					
1. OECEDENT'S NAME (First, Middle, Las)				2. DATE OF DEATH	1		3. TIME OF OEATH		
ROBERT WE.	LEV WAT	SON.			NOVEMISE	DAY	1995	945 P		
4. SOCIAL SECURITY NUMBER	ROBERT WESLEY WATSON 4. SOCIAL SECURITY NUMBER 5. SEK 6. AGE (in yrs. les			IF UNDER 24 HRS.	7. DATE OF BIFTTH		8. BIRTH	PLACE (State or Foreign		
213 10 1734	1 🖾 M 2 🗆 F	91 YRS.	MONTHS DAYS	HOURS MIN.	Feb. 19,	1904	Country	ryland		
9a. FACILITY NAME (If not institution, give	street and number)		9b. CITY, TOWN	OR LOCATION OF D			UNTY OF DE	-		
Harbor Hospit	al Center		Baltim	ore		N/	Δ			
RESIDENCE OF DECEDENT										
10a. STATE 10b. COUN	-		Y, TOWN OR LOCAT	TION				10d. INSIDE CITY LIMITS?		
	ne Arundel	Ba	ltimore					1 TES 2 NO		
10s. STREET AND NUMBER			101	. ZIP CODE		10g. CITIZEN OF WHAT C				
407 Orchard Av	enue			21225			U.S.A	. •		
11. MARITAL STATUS 1 Never Married 2 Married	12. WAS OECEDENT EVER FORCES? 1 YES	IN U.S. ARMED	13. WAS DEC	ENCENT OF HISPAI	NIC ORIGIN? (Specify in, Puerto Rican, etc.)	Yes or No-	14. RACE Black	- American Indian, White, etc.		
3 Widowed 4 Divorced	IF YES, GIVE WAR OR I			2 NO Specif			Specif	ly:		
15. DECEDENT'S EC	I							White		
(Specify only highest gra-	de completed)	(Give kind of v	USUAL OCCUPATION work done during more retired.)	ON st of working	16b. KIND OF	BUSINESS/II		oners Ce		
Elementary/Secondary (0-12)	College (1-4 or 6+)	1			Wood 1	Finich		opers Co.		
17. FATHER'S NAME (First, Middle, Last)		Scacio	nery Engineer Wood Fi					Æpt.		
	Faon			NAME (First, Middle, Meldon Surname) ula Upton						
19a. INFORMANT'S NAME (Type/Print)	Turner R. Watson				La Upton Route Number, City or					
Virginia Watso			venue	Baltimo			nd 21225			
20s. METHOD OF DISPOSITION 1 K Burlei 2 Cremation 3 Re	moval from State	b. PLACE AND DATE O	FOISPOSITION (Na	me of	DATE 20c.	LOCATION -	- City or Ton	wn, State		
4 Donation 6 Other (Specify) Baldwin Mem. Church Cem. 11/10 Millersville							le, Maryla			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY George J. Gonce Funeral Home P.A.										
George J. Gonce Funeral Home P.A. 4001 Ritchie Hwy. Baltimore, Md.										
23. PART i. Enter the diseases, or	complications that couse	d the death. Do n	ot enter the mo	da of dying, suc	h as cardiac or re	spiratory a	rrest.	Approximata		
shock, or heart fellure iMMEDIATE CAUSE (Finel	. List only one ceuse on e	each line.					,	interval Between		
disease or condition	MVG	DRAMI	1417	ABATIA	. 1			Onset slid bya		
resulting in death) s. MYO CARDIAL INFARCTION. DUE TO (OR AS A CONSEQUENCE OF):										
Sequentially list conditions, If any, leading to immediate SUPRAVENTRICVLAR TACHYCARDIA DUE TO (OR AS A CONSEQUENCE OF):										
cause. Enter UNDERLYING CAUSE (Disease or injury										
that initiated events	OUE TO (OR AS	A CONSEQUENCE OF	7:							
resulting in death) LAST	d					et i 220 MIC AN AUTODOV 245 MEDE AUTODOV ENDINGE				
PART II. Other algnificent condition	ons contributing to death i	but not resulting i	n the underlying	ceuse given in	Part I 24a WAS					
		-			PERFORMED? AMAILABLE PRIOR TO					
					1 YES	1 YES 2 NO COMPLETION OF CAUSE OF DEATH?				
DID TORACCO USE CONTRIBUTE TO CAUSE OF DEATH VES TI AIO EX LINICERTAIN TI										
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)										
EXAMINER?	HOSPITAL:		OTHER:		III AVECTOR					
27. MANNER OF DEATH	26a. DATE OF INJURY	26b. TIME			6 Other (Specify)		0011000			
1 Natural 5 Pending	(Month, Day, Year)	INJ	URY WO	RK?	28d. DESCRIBE HO	W INJURY OF	COMED			
2 Accident Investigation 3 Suicide	28a. PLACE OF INJURY	V Al home form a			204 OCATION /C-					
4 Homicide 6 Could not be determined	building, etc. (Spe	icify)	treat, tectory, orne		281. LOCATION (Stra City or Town, St	er and Numbe	N OF HURBI HIC	oute Number,		
29a. CERTIFIER										
(Check only	SICIAN: To the best of my know IER: On the basis of examination							and menner as stated		
29b. SIGNATURE AND TITLE OF CERTIFI			, ,							
1/1/2	: 10.15=	STAFF		29c. LICENSE NUN				(Month, Day, Year)		
30. NAME AND ADDRESS OF PERSON W			Print)	244 16	314-449	1 - 1	OVENI	BEN 06 98		
SARIKUN TJAI	YDRA MA	HARBOR		3001	S. HANNO	1512 513	BAI	TIMOICE MD.		
NOV 0 8 1995	A DESILITATION	' सा ' <u>ह</u>					76			
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ITEM: 1. PER F.H. FILM G-729 11/8/95 t.t

DIVISION OF VITAL RECORDS, P.O. BOX 68760	BALTIMORE, MARYLAND 21215-0020
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 26 hours after death. Page 6 may be totalined by the hospital or attending physician.	sath. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the fur be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	aminer must be notified at once.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	1 - FOR STATE REGISTRAR	STATE OF MAP			TMENT O			MENT	AL HYGIEN	E			
	1. DECEDENT'S NAME (First, Middle, Las								TE OF DEATH	Y	YEAR	3. TIME OF DEATN	
	JAMAAL. 4. SOCIAL SECURITY NUMBER	WILLIAMS 5. SEX 8. /			WILLIAM	-		NO				1027 AM	
	215-80-5522	1. SEX 8.7	AGE (In yrs. I		MONTHS DA		UNDER 24 HRS. DURS MIN.	API	RIL 29	,70	Country)	MD .	
DIRECTOR	9a. FACILITY NAME (If not institution, given 3707 HAYWARD						OCATION OF	DEATN		9c. COUNT		ATH	
	RESIDENCE OF DECEDENT									N/A			
	10a. STATE 10b. COU				T TOWN OR L							10d. INSIDE CITY LIMITS?	
	MD . 100, STREET AND NUMBER	N/A		BA	LTIMO	JKE 101. ZIF	CODE	10g. CITIZEN OF WI				1 X YES 2 NO	
ERA	3707 HAYWARD	AVENUE				100.00		215					
TO BE COMPLETED BY FUNERAL	11. MARITAL STATUS 1XXNever Married 2 Married	12. WAS DECEDENT EV FORCES? 1 📆 IF YES, GIVE WAR	YER IN U.S. A	ARMED NO	If yo		Cuban, Mexi	can, Puerl	GIN? (Specify Yas to Rican, etc.)	or No-	14. RACE Black, Specify	- American Indien, White, etc.	
	3 Widowed 4 Divorced	1988-199	90				ζ				BI	LACK	
	15. DECEDENT'S E (Specify only highest gr	ede completed)	1		vork done during the retired.)		working !	1	16b. KIND OF BUS	INESS/INDU	STRY		
	Elementary/Secondary (0-12)	College (1-4 or 5+)			CAPPI	ER		1	R&R TA	NDSC	APPI	ING CO.	
	17. FATHER'S NAME (First, Middle, Last)			211112	0111 1 1		. MOTNER'S		t, Middle, Maiden			FING CO.	
	DAVID	WILLIAM	1S			I	LINDA			WADE			
	19a. INFORMANT'S NAME (Type/Print)			19b. MAILING	ADDRESS (St	treet and N	Number or Run	I Route No	umber, City or Town	n, Stata, Zip (Code)		
	LINDA WILLIA	MS	3	3707	HAYWA	ARD	AVE.	BAl	LTIMOR	E, MI	D. 2	21215	
	20a. METHOD OF DISPOSITION \$\tilde{\mathcal{L}}\ti			nematory or of	of DISPOSITIO			1		ANSD			
	4 Donation 5 Other (Specify) MT. ZION CEMETERY 11/10 LANSDOWNE, MD. 21. SIGNATURE OF FUNERAL SETVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY BETTS FUNERAL HOME 1129 N. CAROLINE ST. BALTO, MD. 212								HOME				
20	IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions,	DUE TO (OR								_		Onset and Death	
CERTIFICATION	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST	DUE TO (OR DUE TO (OR											
Å	PART ii. Other sign/ficant condit	PERFORMED? AM							WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?				
PHTSICIAN: MEDIC	DID TOBACCO USE CON	OBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN DETENTION TO THE OBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN DETENTION OF THE OBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN DETENTION OF THE OBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN DETENTION OF THE OBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN DETENTION OF THE OBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN DETENTION OF THE OBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN DETENTION OF THE OBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN DETENTION OF THE OBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN DETENTION OF THE OBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN DETENTION OF THE OBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN DETENTION OF THE OBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN DETENTION OF THE OBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN DETENTION OF THE OBACCO USE CONTRIBUTE TO CAUSE OF THE OBACCO USE CONTRIBUT								1 YES 2 NO			
2	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	28, PL	ACE OF OEAT	OTHER:	r one)							
הַ	1XXYES 2 □ NO	1 - Inpatient 2 - ER			4 - Nursing		XReeldenc						
	27. MANNER OF OEATN t Natural 5 Pending	28a. DATE OF INJ (Month, Day, Y			URY	WORK?	1/	28d. I	MSJ3W			SEVE	
red BY	3 Suicide 8 Could not	2 Accident 3 Suicide 8 Could not be 28a. PLACE OF INJURY — At home, ferm, streat, factory, office building, atc. (Specify) 28b. PLACE OF INJURY — At home, ferm, streat, factory, office City or Rown, State)							AT LOPE CITY				
COMPLEIED	COLOCK OINY	IYSICIAN: To the best of my	knowledge,					us to the	cause(a) end mar	ner'es state	d.		
3			metion angre	A Investigatio	m, in my opini				are and pieca, en				
מב	296. SIGNATURE AND TITLE OF CERTI	Yhull					O.C.M			≥ NO		(Month, Day, Year) 7,1995	
2	30. NAME AND APPRESS OF PERSON	A KORFLL	111	Peni		eet	, Bal	tim	ore, M	laryl	and	21201	
	31. DATE FILED (Month, Day, Year) NOV 0 8 1995	2. REGISTRAR'S	SIGNATURE	lall									

DHMH-18 Rev 1/89

Pages 1, 2, 3 should

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page 5 should be detached for

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FOR STATE REGISTRAR CERTIFICATE OF DEATH REG. NO. 2. DATE OF DEATH DAY 30 1995 1. DECEDENT'S NAME (First, Middle, Last) WELK OBIN):23A W. 7. DATE OF BIRTH (Month, Day, Year) Mar. 27,1957 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) # UNDER 1 YEAR # UNDER 24 HRS. 8. DIRTHPLACE (State or Foreig Country) DAYS HOURS 216-68-4175 1 X XM 2 □ F 38 Maryland Sa. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Good Samaritan Hospital Baltimore Baltimore City RESIDENCE OF DECEDENT 10d. INSIDE CITY
X LIMITS?
1 YES 2 NO 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION Maryland Baltimore City Baltimore 10e. STREET AND NUMBER FUNERAL 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 1206 Cox Street 21211 U.S.A. 12. WAS DECEDENT EVER IN U.S. VIRMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-11. MARITAL STATUS 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES If yes, specify Cuben, Maxican, Puerlo Rican, etc.)

1 YES 2 NO Specify: 1 Never Merried 2 X Merried BY 3 Widowed 4 Divorced White 03 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY ive kind of work done Do NOT use retired.) Ē Elementary/Secondary (0-12) College (1-4 or 5 a) COMPL Printer Graphics Company notified at once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First Middle Maiden Surname) Wilbert Welk Ruth Ann Green 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Claudia Welk 1206 Cox Street, Baltimore, Maryland 21211 pe 20e. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must 1 Donation 5 Department (Specify) Meadowridge Memorial 11/6 Dorsey, Maryland examiner 22. NAME AND ADDRESS OF FACILITY Burgee-Henss Funeral Home 21211 3631 Falls Road, Baltimore, Maryland Mynn medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata interval Between Onset and Death IMMEDIATE CAUSE (Final the disease or condition ACUTE R
DUE TO (OR AS A CONSEQUENCE OF) RENAL FAILURE TWO DAYS traumatic event, resulting in dasth) IVER FAILURE A CUTE L
DUE TO (OR AS A CONSEQUENCE OF): 2 WEEKS CERTIFICATION Sequentially list conditions, if any, leading to immediate -YMPHOMA cause. Enter UNDERLYING CAUSE (Disease or injury ONE KEY ONE MONTH or other that initiated events resulting in death) LAST injury, PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE 24a, WAS AN AUTOPSY MEDICAL shows any 1 TYES 2 NO OF DEATH? 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN 🔀 PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? lten. HOSPITAL: Inpetient 2 - ER/Outpetient 3 - DOA OTHER: 4 Nursing Home 5 Residence 10 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked, Natural 5 Pending 1 YES 2 NO BY Investigation 2 Accident 28e. PLACE OF INJURY - At home, farm, street, factory, office 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be determined 49 COMPLETED 28 If Item 29e. CERTIFIER (Check only one)

CERTIFIER (Check only one)

AND THE CERTIFIER TO THE DESCRIPTION OF THE CERTIFIER TO THE DESCRIPTION OF THE CERTIFIER TO THE DESCRIPTION OF THE CERTIFIER TO THE 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occured at the time, date and place, and due to the ceuse(e) end manner ee stated. TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: I 296. SIGNATURE AND TITLE OF CENTIFIE 29d. DATE SIGNED (Month, Day, Year) 29c. LICENSE NUMBER BE acologo MD Nov 8 9 PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) CATHERINE APALOO. GOOD SATM MUSP SLOI LOCH RAVEN BLUD BALTO 21239 NOV 0 8 1995

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

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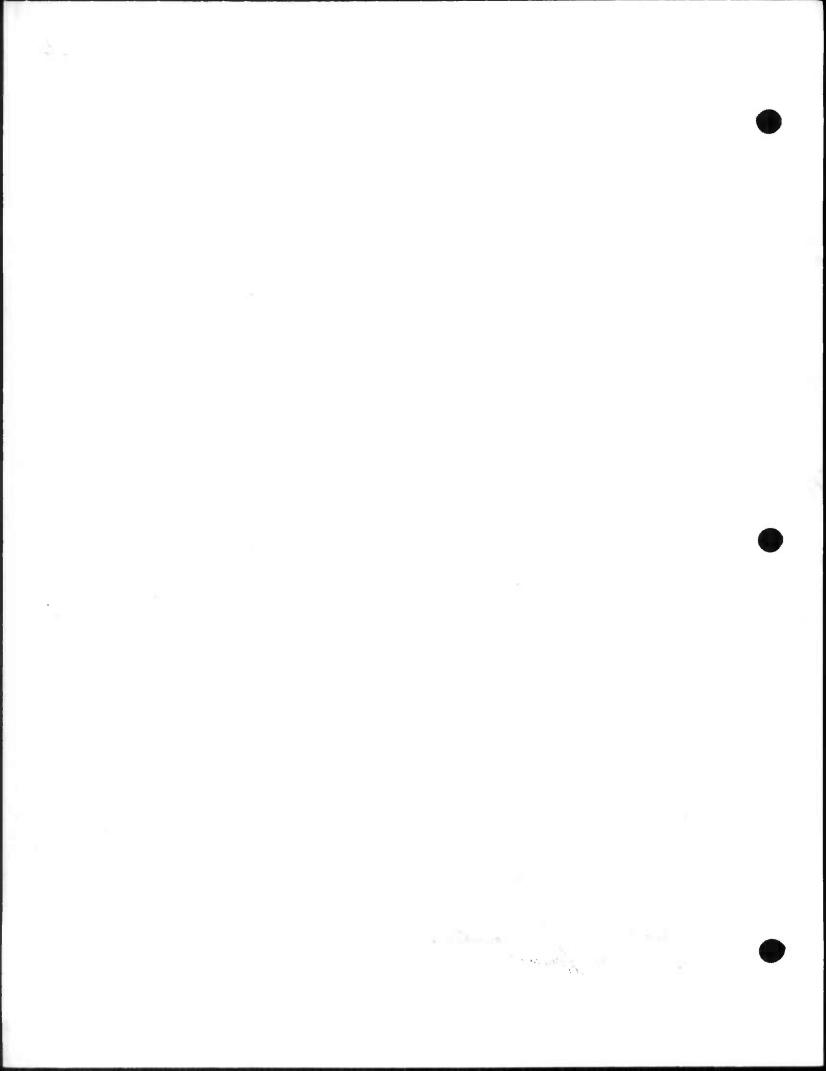
DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Merial Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	REGISTRAR			RITE	CATE OF	DEATH		REG. NO.		
	1. DECEDENT'S NAME (First, Middle, Last)							OF DEATH		3. TIME OF DEATH
	JOHN	М	Ţ	VILLI	AMS		ОСТОТ	BER 31.	1995	5:10 P M
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. lest		IF UNDER 1 YEAR	IF UNDER 24 HRS.	+	OF BIRTH		THPLACE (State or Foreign
	292-46-8270	1 X M 2 - F	46	YRS.	MONTHS DAYS	HOURS MIN.		25. 19	119 Day	ity)
	Ba. FACILITY NAME (If not institution, give si	treet and number)			9h CITY TOWN	OR LOCATION OF DE		3 20 /7	9c. COUNTY OF	GROVE, LA.
œ									SE. COUNTY OF	DEATH
5	THE JOHNS HOPK	INS HOSPI	TAL		BALTI	MORE CIT	<u>Y</u>		$-\nu$	7
DIRECTOR	10a. STATE 10b. COUNTY	1 1		10c. CITY	TOWN OR LOCAT	ION				10d, INSIDE CITY
H	OHio	NA		Si	PRINGB	000				LIMITS?
7	10e. STREET AND NUMBER	- // /		7	11/1/00/2	7IR CODE			44- 0/7/704/ 05	1 ☐ YES 2 12 NO WHAT COUNTRY?
FUNERAL	6560 STATE	0	- 110		"	1/-				
N	6560 STATE					45060			0,3	- //
	1 Never Married 2 Married	12. WAS DECEDENT FORCES? 1	YES 2 N	MED O	13. WAS DEC	ENDENT OF HISPAR ecity Cuben, Maxica	NIC ORIGIN' In, Puerto R	7 (Specify Yes o Ncan, etc.)	r No — 14. RAC Bla	E — American Indian, ck, White, etc.
B∀	3 Widowed 4 Divorced	IF YES, GIVE WA	A OR DATES		1 TES	2 NO Specify	у.		Spe	olly:
	15. DECEDENT'S EDUC	CATION		A CONTRACTOR OF					1 (DHITE
	(Specify only highest grade	completed)	(Gh	e kind of w Do NOT use	JSUAL OCCUPATION ork done during mo	st of working	160.	KIND OF BUSI	NESS/INDUSTRY	
LE	Elementary/Secondary (0-12)	College (1-4 or 5+)	1		,	M= 11		Pow	ER Co	
COMPLETED	/&		0770) KE	30 WH 101	e MECH.				
	17. FATHER'S NAME (First, Middle, Last)	1-1-1-				18. MOTHER'S NA		Middle, Maiden St	imame)	
8		PILLIAM					NIE	SMI	TH	
2	19a. INFORMANT'S NAME (Type/Print)		19b.	MAILING	ADORESS (Street a	nd Number or Rural I				
	DOKIS A. WIL	LIAMS	6	560	STATE	RT. 48	SPR	INGBO	DRO, OF	1. 45060
	20a, METHOD OF DISPOSITION 1 Derial 2 Cremation 3 Remo	ovel Irom State	20b. PLACE Al	NDDATEO	F DISPOSITION (Na	me of	OATE	1 0	ITION — City or 1	
	4 Donation 8 Other (Specify)		MIA	47-6	KOWN	(EM. 11	-6-95	- W	+VNESU	ILLE OH.
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE / /	1 1		22. NAME AP	D ADDRESS OF FA	CILITY	829 ~	LIDSOL	ST.
	1 homes	Skar	la la.		CVA	ADA EL				
	23. PART I. Enter the diseases, or o	complications that	soused the dec	th Door	ONA	I-UN J- FT	/	PALIO	· FID.	21224
	shock, or heart fellure.	List only one ceus	e on each line.	iui. Do ne	or enter the mo	de or dying, suc	n aa card	lec or reapira	tory erreat,	Approximate Interval Between
- 1	IMMEDIATE CAUSE (Final disease or condition	11.	1 /							Onset and Death
	resulting in death)	. Hype	erkale	mio	1					2 days
					E	1				7 /
Z	Sequentielly list conditions,	a Hert	e 12er	al	Fai	Ive				Sweks
Ě	if sny, leading to immediate cause. Enter UNDERLYING	DUE TO (C	OR AS A CONSECU	UENCE OF	1	2 - 6				11 10
일	CAUSE (Disease or Injury	ven	0000	107	ine a	išease				Theets
Ë	that initiated events resulting in death) LAST	DUE 10 (C	JR AS A CONSEO	UENCE OF)		raft	T_	- 1/10	0	12 /0
CERTIFICATION		" ROV	2 may	ron) 6	ratt	1	9110	-	10 weeks
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MEDICAL		pathy						1.		AMAILABLE PRIOR TO COMPLETION OF CAUSE
Σ	DID TOBACCO USE CONTR	pathy			S O NO K	UNCERTAIN		1.		AMAILABLE PRIOR TO COMPLETION OF CAUSE OF OEATH?
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BY PHYSICIAN: M	DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1	RIBUTE TO CAU HOSPITAL: 1 Propertient 2 28e. DATE OF II (Month, Day) 28e. PLACE OF	26. PLACE ER/Outpatient 3 [NJURY , Year)	DOA 28b. TIME	I (Check only one) OTHER: 4 Nursing Hom OF 28c, (NJ) RY WO	UNCERTAIN 5	8 Other 28d. DESC	(Specify)	NO NO URY OCCURED	AMALABLE PRIOR TO COMPLETION OF CAUSE OF OCATH?
BY PHYSICIAN: M	DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1	RIBUTE TO CAU HOSPITAL: 1 Pinpetlant 2 28a. DATE OF II (Month, Day 28a. PLACE OF building, at	26. PLACE ER/Outpetient 3 [NJURY , 'Year) INJURY — At homitic. (Specify)	DOA 28b. TIME INJU	OTHER: 4 Nursing Hom OF RY M 28c. INJ WO 1 1	UNCERTAIN 5	8 Other 28d, DESC 28l, LOCA City o	(Specify) CRIBE HOW INJ ATION (Street and reference)	URY OCCURED	AMALABLE PRIOR TO COMPLETION OF CAUSE OF OCATH?
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COMPLETED BY PHYSICIAN: M	DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1	RIBUTE TO CAU HOSPITAL: 12 Operlant 2 28a. DATE OF II (Month, Day 28a. PLACE OF building, of	26. PLACE ER/Outpetient 3 [NJURY , /ber/) INJURY — At hom tc. (Specify) my knowledge, deat	DOA 28b. TIME INJU	OF CONTROL OF CONTROL	UNCERTAIN 5 G Residence URY AT RK? YES 2 NO and place, and due eath occured at the	8 Other 28d. DESC 28l. LOCA City o	(Specify) CRIBE HOW INJ ATION (Street and rown, State)	URY OCCURED I Number or Rural or as stated, due to the cause	AMALABLE PRIOR TO COMPLETION OF CAUSE OF OEATH? 1 YES 2 NO Route Number, a) and manner as stated.
BY PHYSICIAN: M	DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1	RIBUTE TO CAU HOSPITAL: 12 Operlant 2 28a. DATE OF II (Month, Day 28a. PLACE OF building, of	26. PLACE ER/Outpetient 3 [NJURY , /ber/) INJURY — At hom tc. (Specify) my knowledge, deat	DOA 28b. TIME INJU	I (Check only one) OTHER: 4 Nursing Hom OF 28c. INJ RY M 1 1	UNCERTAIN 5 G Residence URY AT RK? YES 2 NO and place, and due seth occured at the 29c. LICENSE NUM	8 Other 28d, DESC 28l, LOCA City o	(Specify) CRIBE HOW INJ ATION (Street and rown, State) se(a) and manner and placa, and	URY OCCURED I Number or Rural or as stated. due to the cause	AMALABLE PRIOR TO COMPLETION OF CAUSE OF OEATH? 1 YES 2 NO Route Number, (a) and manner as stated.
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BE COMPLETED BY PHYSICIAN: M	DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1	RIBUTE TO CAU HOSPITAL: 1 Superlant 2 28a. DATE OF II 28a. DATE OF II (Month, Day 28a. PLACE OF building, et	26. PLACE ER/Outpetient 3 [NJURY , /bear) INJURY — At home to (Specify) my knowledge, deat amination and/or in the Company to the Company	DOA 28b. TIME INJU	I (Check only one) OTHER: 4 Nursing Hom OF 28c. INJ RY M 1 1	UNCERTAIN 5 G Residence URY AT RK? YES 2 NO and place, and due seth occured at the 29c. LICENSE NUM	8 Other 28d, DESC 28l, LOCA City o	(Specify) CRIBE HOW INJ ATION (Street and rown, State) se(a) and manner and placa, and	URY OCCURED I Number or Rural or as stated. due to the cause	AMALABLE PRIOR TO COMPLETION OF CAUSE OF OEATH? 1 YES 2 NO Route Number, (a) and manner as stated.
BE COMPLETED BY PHYSICIAN: M	DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1	RIBUTE TO CAU HOSPITAL: 1 Superlant 2 28a. DATE OF II 28a. DATE OF II (Month, Day 28a. PLACE OF building, et	26. PLACE ER/Outpetient 3 [NJURY , /sear) INJURY — At hom fic. (Specify) Try knowledge, deat amination and/or in E OF OEATH (ITEM	DOA 28b. TIME INJU	I (Check only one) OTHER: 4 Nursing Hom OF 28c. INJ RY M 1 1	UNCERTAIN 5 G Residence URY AT RK? YES 2 NO and place, and due seth occured at the 29c. LICENSE NUM	8 Other 28d, DESC 28l, LOCA City o	(Specify) CRIBE HOW INJ ATION (Street and rown, State) se(a) and manner and placa, and	URY OCCURED I Number or Rural or as stated. due to the cause	AMALABLE PRIOR TO COMPLETION OF CAUSE OF OEATH? 1 YES 2 NO Route Number, a) and manner as stated.



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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31. NOV 0 W8 1995

TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	TIEM: 2	3 PARI I	.1, PER DR.	FILM 6-	/29 11,	15/95	t.t					•		00030
	FOR STATE REGISTRAR		STATE OF I		DEPAR					MENTAL HY	GIENE			
	1. DECEDENT'S NAME (First	, Middle, Last)								2. DATE OF DE			-	3. TIME OF DEATH
	Dorothy E	sther	Whitmore							Nov.	4		95	5:45 P. M
	4. SOCIAL SECURITY NUME	BER	5. SEX	6. AGE (In yrs. I	ast birthday)	IF UNDER	YEAR	IF UNDE	R 24 HRS.	7. DATE OF BIE	TH		8. BIRTH	IPLACE (State or Foreign
	217-01-1904		1 🗆 M 2 😾 F	82	YRS.	MONTHS	DAYS	HOURS	MIN.	Jan. 20	6, 1	013	Mox	yland
	9a. FACILITY NAME (If not in	stitution, give a	reet and number)			9b. CITY	TOWN C	R LOCAT	ION OF DI		, 1		NTY OF D	
œ	Westminster													
DIRECTOR	RESIDENCE OF DEC		ing nome			W	esti	inst	Ler			Car	roll	
Ĕ	10a. STATE	10b. COUNTY	,		10c. CIT	Y, TOWN OF	R LOCAT	ION						10d. INSIDE CITY
뚬	Maryland	Ken	t			Steve	ensv	71116	2					LIMITS?
	10e. STREET AND NUMBER							ZIP COD				10g, CIT	IZEN OF V	WHAT COUNTRY?
FUNERAL	104 North L	ake Dr	ive					2166	56					States
Ξ	ti. MARITAL STATUS		12. WAS DECEDEN	IT EVER IN U.S. A	RMED	13. W	WAS DEC			NIC ORIGIN? (Spe	offy Vea			
	t Never Married 2	Married		YES 2 X		If	yes, spe	ecify Cubi	on, Maxica	in, Puarto Rican,			0.00	- American Indian, k, White, atc.
B∀	3 XWidowed 4 Divo	rced	17 165, 0176 1	AN ON DATES			U 169	Z DE NO	Specif	у:			Speci	White
		EDENT'S EDUC y highest grade			ECEDENT'S					186. KIND	OF BUSI	NESS/INC	DUSTRY	
Щ	Elementery/Secondary (6		College (1-4 or 5	- 1	Give kind of fe. Do NOT u	se retired.)	unng mo	St or work	ng					
릴	11th grade				Booke	eper	& S	ales	cle	erk Phan	rmac	euti	cal	Cpmpany
COMPLETED	17. FATHER'S NAME (First, M	liddle, Last)								ME (First, Middle,	_			
ш	Romulus Gr	iffith	Gardner					A	Annie	Esther	r Da	V		
B	194. INFORMANT'S NAME (Type/Print)		1	96. MAILING	ADDRESS	(Street e	nd Numbe	r or Rural	Route Number, Cit	y or Town,	State, Zip	o Code)	
임	Mrs. Diane	Kicas			3495	Kirby	v Ko	unti	v Di	rive Ta	anev	town	. MD	21787
	20a. METHOD OF DISPOSIT				E AND DATE	OF DISPOSI							City or To	
	tx Burial 2 ☐ Crematic 4 ☐ Donation 5 ☐ Other		oval trom State	Wood	rematory or clawn	Ceme 1	terv	,		11/7	Wo	od1a	wn,	MD
	21. SIGNATURE OF FUNERA	L SERVICE LIC	ENSEE						SS OF FA		110	oula	WIL	ND
	1 / ha	man-	160 (1	0/1/	2 Lo	orin	ig By	rers	Funeral	l Di	rect	ors,	Inc.
	Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 21133													
	23 PART Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Battween Interval Battween													
	IMMEDIATE CAUSE (FI	nel			/_	/			1.1	1 /	0	/		Onset and Death
	diseasor condition resulting in deeth) e. Chronic Obstanct. 20 Polycong Mispers 3413.													
			DUE TO	(OR AS A CONS	EOUENCE C	F):								
N	Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF):													
CERTIFICATION	If any, leading to imme cause, Enter UNDERLY		506 10	(ON AS A CONS	EODENCE O	r j.								ĺ
5	CAUSE (Disease or Inju		C. DUE TO	(OR AS A CONS	FOLIENCE O	F)·								
Ē	that initiated evente resulting in death) LAS	т		(ott no n ootto		. ,.								j
			d								-			
4	PART II. Other signification of the signification of the signification of the significant	nt condition	e contributing to	death but not	resulting	In the und	derlying	ceuse	given in	Part i. 24e.	WAS AN A		24b	WERE AUTOPSY FINDINGS
5	A+11	_ F,	bollet.	21							PERFORM			AVAILABLE PRIOR TO COMPLETION DF CAUSE
	Miti-1	V	1/2	10/0/01	18					_ ' ' '	100 1	_ 110		OF DEATH?
PHYSICIAN: MEDICA	DID TOBACCO U	ISE CONTI	RIBUTE TO CA	USE OF DE	ΔΤΗ Υ	STATE	TO IX	X LING	CERTAI	NΠ				1 YES 2 NO
¥	25. WAS CASE REFERRED T				ACE OF DEA									
Sic	EXAMINER?		HOSPITAL:	ER/Outpatient	3 [] DOA	OTHER	l:	a 6 🗆 B	aeldance	8 Other (Spec	n/hal			
Ξ	27. MANNER OF DEATH	`	28e. DATE OF	INJURY	28b. TIR	E OF	28c. INJ	URY AT		28d. DESCRIBE		JURY OC	CURED	
		Pending Investigation	(Month, E	Day, Year)	IN	JURY M		RK?	NO					
BY	2 Accident 3 Suicide	Could not be	28a. PLACE (OF INJURY — At	home, farm,	street, tecto	ory, offic	0		28t, LOCATION		nd Number	r or Rumi I	Route Number,
COMPLETED	4 Homicide	datermined	building	, atc. (Specify)						City or Tow	n, State)			
۳ ا	290. CERTIFIER	LIEVING BHASI	CIAN: To the best of	l any knowledge	de ath assure	and an about		and stee		A- 4b(-)				
M M	anal													e) end menner as stated.
8					v v rigati									
H	296. SIGNATURE AND TITLE	OF CERTIFIED	61-	mo			į		ENSE NU			29d. DAT		(Month, Day, Year)
2	20 NAME AND ADDRESS OF	0 0 /	V152,		Whi are -			03	28	7 -			11/6	6/92
	30. NAME AND ADDRESS O	F FERSON WH	COMPLETED CAU		'EM 27) (Type / 🖌	Rus.			(0-	6. 1	2		Pais	Lucture Mil
- 1	1000	Gr 5	1/1040			0801	-12	- Mar. 1	CF	0	PIVT		- T //	1111000

DHMH-16 Rev 1/89

21136

Leve a vev

			1 - STATE REGISTRAR	STATE OF MARY		TMENT OF H		MENTAL HYGIEN		
		1	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH MONTH D	AY YEA	3. TIME OF DEATH
			LFROY	WILKES			T	Nov. 4	1995	9:55 am
	pin	9	4. SOCIAL SECURITY NUMBER 229-16-5589	1 X M 2 🗆 F	74 YRS.	IF UNDER 1 YEAR MONTHS DAYS			1921 000	WIRGINIA
	, 2, 3 should	CTOR	96. FACILITY NAME (If not institution, give a 1812 Payson Stre	1000		Contract of the Contract of th	MORE CIT		9c. COUNTY O	
	t. Pages 1,	DIREC	10e. STATE 10b. COUNTY MARYLAND		10c. CITY, TOWN OR LOCATION				10d. INSIDE CITY LIMITS? 1 X YES 2 NO	
	it permit.		100. STREET AND NUMBER				I. ZIP CODE			F WHAT COUNTRY?
o ician.	burial-transft	FUNERAL	1812 N. Payson S	12. WAS DECEDENT EVER		13. WAS DEC	21217 ENDENT OF HISPANI	C ORIGIN? (Specify Yes	or No.— 14. R.	J.S.A. ACE — American Indian,
215-0020 attending physician.	as the buri	BY	1 Never Married 2 Merried 3 Wildowed 4 Divorced	FORCES? 1 TYES		If yes, sp 1 YES	ecify Cuban, Mexican 2 NO Specify:	, Puerto Rican, etc.)	В	leck, White, etc. pecity: BLACK
2121!	5	TED	15. DECEDENT'S EDUI (Specify only highest grade	CATION completed)	16e. DECEDENT'S (Give kind of ville. Do NOT us	USUAL OCCUPATION	ON ast of working	16b. KIND OF BU	SINESS/INDUSTR	
	ned for	COMPLET	8th grade	College (1-4 or 5+)	Steelwo			Bethle	ehem Ste	el
MARYLAND 2 retained by the hospital	detached once.	SON	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAM	NE (First, Middle, Maiden		
MARYL retained by	2 %	BE (George Wilkes					Thorne		
60	page 5 should be notified	2	Bernetta L. Wilke	<u>s</u>	196. MAILING	Meadowo	ood St. G	oute Number, City or Tow reensboro	n, Stete, Zip Code) North	Car61409
IMORE Page 6 may	ector, pa		20a. METHOD OF DISPOSITION 1\(\) Burtal 2 \(\) Cremetion 3 \(\) Remode Remode A \(\) Donation 5 \(\) Other (Specify).	oval from State 20	b. PLACE AND DATE of the control of	OF DISPOSITION (Na	ama of	DATE 20c. LO	CATION - City or	
E Page	al dire		21. SIGNATURE OF FUNERAL BERVICE LIC		Arbucus	22. NAME AL	ND ADDRESS OF FAC	ILITY		
BALTIMORE, after death. Page 6 may b	n by the funeral director, removal.	_	· Hari	y. U	lose	1206	W. NORT	ROWN COMMU H AVENUE		′H
thir 24 hours	pletely filled in cremation, or rent, the mo		23. PART I. Enter the diseases, or cahock, or heart fellure. IMMEDIATE CAUSE (Final disease or condition resulting in death)	. Matasta	each line.	mall.		CANC		Approximate interval Batween Onset and Death
, P.O. BOX	ires that the death certificate be executed signed by the attending physician and com- teath and Mernal Hygiene prior to buria, ws any injury, or other traumatic en	CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	G	A CONSEQUENCE OF					
Q å		MEDICAL		ON CAN	CER.			Part I. 24a. WAS AN PERFOR	MED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 AO
20	Sept 23	AN	DID TOBACCO USE CONTE	RIBUTE TO CAUSE C	26. PLACE OF DEAT		UNCERTAIN			
VITAL IAN: The lav	State State	SICI	EXAMINER?	HOSPITAL:		OTHER:	e 5 A Reeldence 6	Comme (Proceeding)		
OF	this with	Y PHYSICIAN:	27. MANNES OF DEATH 1 Natural 5 Pending Investigation	26s. DATE OF INJURY (Month, Deg. Weer)	28b. T/M	E OF 29c. INJ URY WO		28d. DESCRIBE HOW II	NJUNY OCCURED	
DIVISION OF VI	after d	TED BY	Accident Investigation Suroide II Could not be Homicide datermined	28s. PLACE OF INJUR building, etc. (Spe	Y — At home, farm, a scriy)	Breef, factory, office	•	28f. LOCATION (Street a City or Town, State)	and Number or Plun	ni Route Numbec
5	RAL OIREC	COMPLET		CIAN: To the best of my known:						
THE HOSPITAL	TO THE FUNERAL be filed within 72 P IMPORTANT: If I	జ	SIGNATURE (NO TITLE OF CENTRAL	7 MD	*		29c. LICENSE NUM			ED (Models Day Mar)
2	28₹	5	30. HAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DI	EATH (ITEM 27) (Type,	BALT	TMAN	E. MO	71	201
_ (-		31. DATE FILED (M877 8995")	A STORY SIGN	NATURE	13.401	177072	(1000	. 61	

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BALLIMORE, MARTLAND 21203-3140	in \$4 Jurs after death, Page 6 may be retained by the hospital or attending physician.	TO THE FLINERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	
DIVISION OF VITAL RECORDS, P.O. BOX 13140,	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within to Juns after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and compilete be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, crem.	

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR		PARTMENT OF I		REG. NO.								
	1. DECEDENT'S NAME (First, Middle, Lest)	241			2. DATE OF DEATH	VEAD	3. TIME OF OEATH						
	Carrie Willi	ams			MONTH 6	95 ^r	7:50 A m						
	4. SOCIAL SECURITY NUMBER 5. SEX	6. AGE (In yrs. lest birth	MONTHS DAYS	IF UNDER 24 MRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	Country	PLACE (State or Foreign y)						
	216-16-9435 1 ¹ M ²	11 31	MS.		01/21/01		i Burnie M						
~	Sa. FACILITY NAME (If not institution, give street and num	*	I '	OR LOCATION OF DEA	TH 90	c. COUNTY OF O	EATH						
<u>ē</u>	Greenspring Nursing &	Renab Center	Baltimo	ore City		N/A							
DIRECTOR	10a. STATE 10b. COUNTY	100	c. CITY, TOWN OR LOCA	TION			10d, INSIDE CITY LIMITS?						
	MARYLAND N/A	4	BALTIM	ORE CITY			1XXYES 2 NO						
AL	10s. STREET AND NUMBER		.10	r. ZIP CODE	10	0g. CITIZEN OF W	VHAT COUNTRY?						
FUNERAL	801 E. COLDSPRING LAN			21212		U.S.A							
ᆵ	1 News Married 2 Married FORCE	ECEDENT EVER IN U.S. ARMED	If yes, s	pecify Cuben, Mexicen,	C ORIGIN? (Specify Yee or ! Puerto Rican, etc.)	No — 14. RACE Black	— American Indian, k, White, etc.						
8	3 💢 Widowed 4 □ Divorced	, GIVE WAR OR DATES	1 TYE	S 2 XXIVO Specify:		Bla	Čk						
	15. DECEDENT'S EDUCATION	16a, DECEDI	ENT'S USUAL OCCUPAT	ION	16b. KIND OF BUSINE	ESS/INDUSTRY							
E	(Specify only highest grade completed) Elementary/Secondary (0-12) Coffee (1	Min Do I	ind of work done during m NOT use retired.)	ost or working									
를	6th grade	Fol de	er		Archer I	Laundry							
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				E (First, Middle, Meiden Surr	mame)							
BE	UNKNOWN			LUNKNOW									
2	19a. INFORMANT'S NAME (Type/Print)				oute Number, City or Town, St								
	Rev. Reginald Boston	801	DISPOSITION (Name of co		Baltimore	e. Mary							
	XIX Burial 2 Cremation 3 Removal from S	tate other place)											
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	LGargen		ND AOORESS OF FACI	ILITY		r.Maryland						
	1	Poro	WILL	IAM C. BRO	OWN COMMUNIT	TY F/H							
_	22 PADTI. Enter the diseases or complication	Leste	WILLIAM C. BROWN COMMUNITY F/H 1206 W. NORTH AVENUE										
	23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between												
			. Do not enter the m	ode of dying, such	as cardiac or respirate	ory arrest,	Interval Between						
	shock, or heart failure. List only o	one cause on each line.			·								
	shock, or heart failure. List only o	one cause on each line.			·		Interval Between						
7	shock, or heart failure. List only of IMMEDIATE CAUSE (Final disease or condition resulting in death)	A CM TE	RESTI	RATORY	FAIL Y RE		Interval Between						
rion	shock, or heart failure. List only of IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions,	A CM TE	RESPICE OF):	RATORY	FAIL Y RE		Interval Between Onset and Death						
CATION	shock, or heart failure. List only of IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Cliesses or Indury.)	DUE TO (OR AS A CONSEQUENT)	RESPITORE OFF:	RATORY	FAIL Y RE		Interval Between Onset and Death						
TIFICATION	shock, or heart failure. List only of IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	DUE TO (OR AS A CONSEQUENT ARTER!)	RESPITORE OFF:	RATORY	FAIL Y RE		Interval Between Onset and Death						
SERTIFICATION	shock, or heart fellure. List only of IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if arry, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	DUE TO (OR AS A CONSEQUENT)	RESPITORE OFF:	RATORY	FAIL Y RE		Interval Between Onset and Death						
	shock, or heart failure. List only of IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	DUE TO (OR AS A CONSEQUENT OF AS	RESPIP NOTE OFF: NOTE OFF:	LATORY IC ITEMS	FAIL URE DISCUSSE	TIOPSY 24b	Interval Between Onset and Death D.B.Y. Y.E.A.T.S.						
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BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	TATE OF MARYLAN	D / DEPARTM			IENTAL HYG					
	1. OECEOENT'S NAME (First, Middle, Last)					2. DATE OF OEA	TH		. TIME OF OEATH		
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	4. SOCIAL SECURITY NUMBER 5. S 215–20–2578 1X	6. AGE (In y		UNDER 1 YEAR	IF UNDER 24 HRS	7. DATE OF BIRT	н	S. BIRTHPL	ACE (State or Foreign		
OR	9a. FACILITY NAME (If not institution, give street a NION MEMO		PITAL OB		MORE	TH		TY OF OEA	тн		
اظ	RESIDENCE OF DECEDENT 19a, STATE 19b, COUNTY			OWN OR LOCATION							
DIRECTOR	Maryland Baltimo	re City		timore	ON			1	Od. INSIDE CITY LIMITS? YES 2 NO		
FUNERAL	100. STREET AND NUMBER 1406 Redfern Avenue	;		101.	21211		10g. CITIZ	U.S.	AT COUNTRY?		
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00	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAM		feiden Surname)				
BE	Unknown		T		0.2.2.0						
9	190. INFORMANT'S NAME (Type/Print) Robin Ross-Hutson				Number or Rural Ro			,	land21236		
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	20s. METHOO OF DISPOSITION 12 Burisl 2 Cremation Removal 6 4 Donation 5 Other Specify)	[V]	eadowrid	ge Memo	rial 1	1/7 0	orsey,				
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	21. SIGNATURE OF FUNERAL STRVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY BURGEE-Henss Funeral Home 21211 3631 Falls Road, Baltimore, Maryland										
	23. PART i. Enter the difference, or complications the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ahock, or heart failure. List pniy one cause on each line. Approximate interval Between Onset and Death										
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_		COPD							15 yns		
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Ä	d.	that initiated events resulting in death) LAST d									
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IAN	25. WAS CASE REFERRED TO MEDICAL		PLACE OF OEATH								
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붓	27. MANNER OF OEATH	28a. OATE OF INJURY (Month, Day, Year)	28b. TIME C			28d. OESCRIBE	HOW INJURY OCC	URED			
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8	3 Suicide 6 Could not be 4 Homicide determined	28s. PLACE OF INJURY — building, stc. (Specify,	At home, ferm, stre	et, factory, office		261. LOCATION (City or Town,	Street and Number State)	or Rural Ro	ute Number,		
COMPLET	29a. CERTIFIER 1 CERTIFYING PHYSICIAN	: To the best of my knowled	foe, death occurred a	it the time, data	and place, and due t	to the cause(a) a	nd manner as stat	ed.			
ME	(Check only one) 2 MEOICAL EXAMINER: On	•			-				and manner se stated.		
	29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUM	BER	29d. DATE	SIGNED (Month, Day, Year)		
) BE	AunaWathan	M.D.			AT 243			vembe			
10	30. NAME AND ADDRESS OF PERSON WHO CO				1 Hospil	tal					
	31 NOV 0 8 1995	2. REDISTRAR'S SIGNAT	URE								

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DIVISION OF VITAL RECORDS, P.O. BOX 68760	BALTIMORE, MARYLAND 21215-0020
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a hours after death. Page 6 may be retained by the hospital or attending physicia	ours after death. Page 6 may be retained by the hospital or attending physici
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-to filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	d in by the funeral director, page 5 should be detached for use as the burial-tor removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.	medical examiner must be notified at once.

THEODOR ROSSBACK - STATE OF DEATH - REGISTRAR - REGISTR		FOR	CTATE OF MADVI AND /	DEDA DINAFALT O		APAITAL ANVOITAGE		33597			
GERALDINE VERONICA ALEXANDER 1. SOCIAL SECURITY MAMBER 14, 1995 1. SOCIAL SECURITY MAMBER 215-52-2368 1. SEX 75 YRS. SECORY SECURITY MAMBER 215-52-2368 1. SEX 75 YRS. SECORY SECURITY MAMBER 325 SECORY SECONDARY OF DEATH SECONDARY OF PART OF SHIPM WORKESTER. 1. SECORY SECONDARY OF SECON		1 STATE					Ŀ				
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Se FACILITY NAME (If not natisfactor, pays abrest and number) ATLANTIC GENERAL HOSPITAL RESIDENCE OF DECEDENT 16. STATE 10. STREET AND NUMBER RD \$2 BOX 431, E. LAGOON ROAD 10. STREET AND NUMBER RD \$2 BOX 431, E. LAGOON ROAD 11. MARITAL STATUS 10. WEST DECEDENT SEVERAL BOSE SEX 10. STREET AND NUMBER RD \$2 BOX 431, E. LAGOON ROAD 11. MARITAL STATUS 10. NORE SECRET SEVERAL BOSE SEX 10. STREET AND NUMBER RD \$2 BOX 431, E. LAGOON ROAD 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ANABED 13. WAS DECENERT OF HISPANC ORIGIN' (Specify Yes or No— 14. SECRET SEVERAL SOUTH SEVERAL BOSE SEX 15. STREET AND NUMBER 16. STREET AND NUMBER 17. MARITAL STATUS 18. SECRET SEVERAL SOUTH SEVERAL SOUTH SEVERAL BOSE SEX 19. STREET AND NUMBER 19. STREET AND NUMBER 19. SECRET SEVERAL SOUTH SEVERAL SOUT				MONTHS DA		7. DATE OF BIRTH	A BIRT	HPI ACE (State or Foreign			
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100. STREET AND NUMBER 101. ZIP CODE 102. CTIZEN OF WHAT COUNTRY USA	ECT			10c. CITY, TOWN OR LO	CATION		10d. INSIDE CITY				
The Decedent's Education Specify: Spec			SEX	DAGSB			1 TES ZX NO				
The Decedent's Education Specify: Spec	VERA	RD#2 BOX 431, E. L	AGOON ROAD					WHAT COUNTRY?			
Elementary/Secondary (6-12) College (1-4 or 5+) HOUSEWIFE	ВУ	1 Never Married 2 X Morried	FORCES? 1 YES 2 X N	O II yes	, specify Cuben, Mexices	n, Puerto Rican, etc.)	Blac	ck, White, etc.			
THEODORE ROSSBACK 19a. INFORMANT'S NAME (Type/Print) LOUIS M. ALEXANDER 19b. MAILING ADDRESS (Street and Number or Flural Route Number, City or Rown, Stella, Zip Code) RD#2 BOX 431, E. LAGOON RD, DAGSBORO, DE. 19939 20a. METNO OF DISPOSITION 1 DATE Committee and DATE of DISPOSITION (Number of Carried or Printing Carried or Printing Carried or Carried or Printing Carried or Carr	PLETED	(Specify only highest grade comp	college (1-4 or 5+)	ve kind of work done during Do NOT use retired.)	ATION I most of working						
196. INFORMANT'S NAME (TyperPrint) 196. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, Stale, Zip Code) 10 INFORMANT'S NAME (TyperPrint) 11 INFORMANT'S NAME (TyperPrint) 12 INFORMANT'S NAME (TyperPrint) 13 INFORMANT'S NAME (TyperPrint) 14 INFORMANT'S NAME (TyperPrint) 15 INFORMANT'S NAME (TyperPrint) 15 INFORMANT'S NAME (TyperPrint) 16 INFORMANT'S NAME (TyperPrint) 17 INFORMANT'S NAME (TyperPrint) 18 INFORMANT'S NAME (TyperPrint) 19 INFORMANT'S NAME (TyperPrint) 19 INFORMANT'S NAME (TyperPrint) 19 INFORMANT'S NAME (TyperPrint) 20 INFORMANT'S NAME (TyperPrint) 21 INFORMANT'S NAME (TyperPrint) 22 INFORMANT'S NAME (TyperPrint) 22 INFORMANT'S NAME (TyperPrint) 23 INFORMAN	COM						,				
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Carter 2 Cremation 3 Removal from State								19939			
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T YES 2 YOUND COMPLETION OF DEATH	PHYSICIAN: MEDICAL										
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296. SIGNATURE AND TITLE OR CERTIFIER 296. LICENSE NUMBER 296. DATE SIGNED (Month, Day, Year)	BE	2 MEDICAL EXAMINENT On the bests of exemination end/or Investigation, in my opinion, death occured at the ilms, date end place, end due to the cause(e) and menner es stated.									
DR. HABIB BOLOURCHI, M.D. 4503 HICHWAY 1, REHOBOTH BEACH, DE. 19971	ř		· ·		REHOBOTH B	BEACH DE . 1	.9971	7.1			

DR. HABIB BOLOURCHI, M.D. 4503 HICH

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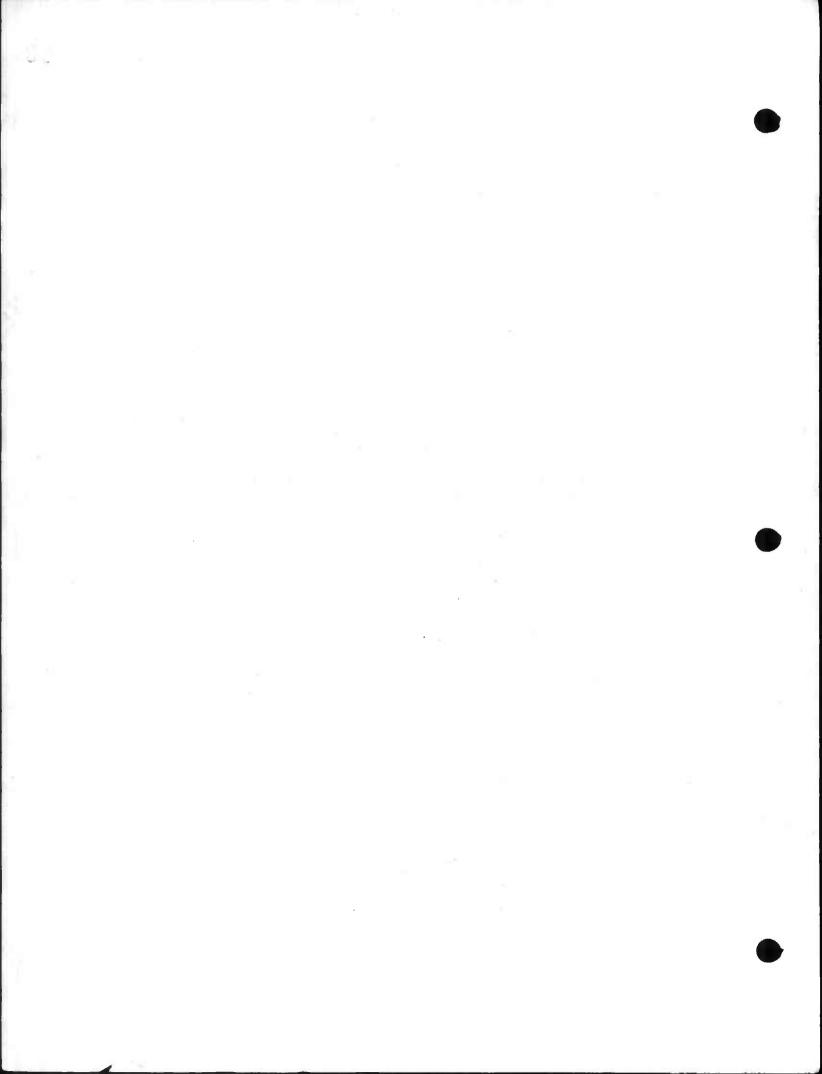
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STAT	E OF	MARYLAND	/ D	EPARTMENT	0F	HEALTH	AND	MENTAL	HYGIE	NE
			E	RTIFICATE	0	F DEAT	TH		REG. N	10.

		1 - STATE OF STATE OF I	MARYLAND / DEI CERT	PARTMENT OF I	HEALTH AND M	IENTAL HYGIENE REG. NO.		
		1. DECEDENT'S NAME (First, Middle, Lest) Susie M	A.	lmasi		2. DATE OF DEATH DAY OCTOBER 11	100 YEAR	3. TIME OF DEATH 5:30 P
B		4. SOCIAL SECURITY NUMBER 5. SEX 1 □ M 2 🖫 F	6. AGE (In yrs. last birth	111111111111111111111111111111111111111	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Dey, Year) MAR 27, 192	8. BIRT	HPLACE (State or Foreign
1, 2, 3 should	стоя	99. FACILITY NAME (If not institution, give street and number) Berlin Nursing & Rehabili RESIDENCE OF DECEDENT	tation Cer		or location of dea		Worce	DEATH
permit. Pages	FUNERAL DIRE	10e. STATE 10b. COUNTY Maryland Worcester 10e. STREET AND NUMBER	100		10d. INSIDE CITY LIMITS? 1 X YES 2 NO			
. isi		208 B William Street		10	21811	10	WHAT COUNTRY?	
al or attending physician. for use as the bun'al-transit	Β¥	Never Merried 2 Merried FORCES?	NT EVER IN U.S. ARMED VES 2 NO MAR DR DATES	If yea, sp		C ORIGIN? (Specify Yee or , Puerto Ricen, etc.)	No- 14, RAC	E — Americen Indien, k, White, etc.
ital or attending of for use as the	LETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4 or 5	+) (Give kin life. Do N	NT'S USUAL DCCUPATE d of work done during me OT use retired.)	ON ost of working	16b. KIND OF BUSINE		
the hospital o detached for once.	COMPLET	17. FATHER'S NAME (First, Middle, Last)	Sea	mstress	18. MOTHER'S NAM	Garmen E (First, Middle, Malden Surr		
d by th	BE C	Joseph Almasi, Sr.			Clara			
retained by the hospit 5 should be detached notified at once.	2	190. INFORMANT'S NAME (Type/Print) Margaret A. Almasi				oute Number, City or Town, S O, Delaware		
		20a. METHOD OF DISPOSITION 14 Burlel 2 Cremetion 3 Removal from State	20b, PLACE AND D	ATE OF DISPOSITION (N	eme of		TON — City or To	own, State
age 6 mar director, p		4 Donetion 5 Other (Specify)	Rivers	ide Cemet		10/14 Libe	rtytown	n, Maryland
after death. Page 6 may be by the funeral director, page moval.		Rechard T. Wa	tra	Watso 211 V	Vashington	l Home, Inc n Street, M	illsbor	co, Delaware
within 24 hours appetely filled in the cremation, or reservent, the median	N. S.	23. PART I. Entar tha diseases, or complications the ehock, or heert fellure. Liet pnly proceed immediate CAUSE (Finel disease or condition resulting in deeth)	uee Dn eech line.			DISCHAS		Approximate Interval Between Onset and Dasth
certificate be execute noting physician and co Hygiene prior to burian other traumatic	ERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or Injury	OR AS A CONSEDUENT	cl.	_			
T d th	AL C	PART II. Other eignificent conditions contributing to	deeth but not result	ing in the underlyin	g ceuee given in P	Part 1. 24e. WAS AN AUT		. WERE AUTOPSY FINDINGS
requires that the been signed by the signed	MEDIC					PERFORMEI		AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
d: The law cate has b State Dept.	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL:		26. PI	ACE DF DEATH (Chec	ok only one)		
PHYSICIAN this certifi with the with the	PHY	1 ☐ YES 2 ₹ NO 1 ☐ Inpatient 2 € 27. MANNER OF DEATH 1 ★ Netural 5 ☐ Pending		TIME OF UNUTABLE O	URY AT DRK? YES 2 ND	Other (Specify) 26d. DESCRIBE HOW INJU	RY OCCURED	
TTENDI TOR: A after d	TED BY	3 Suicide 28e. PLACE I	PF INJURY — At home, fa atc. (Specify)	rm, atreet, fectory, offic	•	201. LOCATION (Street and I City or Yown, State)	Number or Rural	Route Number,
4 4 2 =	COMPLET	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of examiner: Dn the best of examiner:						s) end menner ee stated.
TO THE HOSPIT TO THE FUNERS be filed within 7	TO BE CO	29b. SIGNATURE AND TITLE DESCRIPTION 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAU	SE OF DEATH (ITEM 27)	(Seno Orist)	29c. LICENSE NUME DO202	100	D CA	(Month, Day, Year)
		Federico G. Arthes, MD 1 31. DATE FILED (Month, Day, Year) 32. REGISTR.	622A Ocean	Pines Be	erlin, MD	21811 410-	-641-63	63
*		OCT 16 1995 Julia	Studior Ran	lath			_	



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunla-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlal, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 - STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO.

	REGISTRAN		- CL	LA FIE	ICAIL	- 01	DEA	111		HEG. NO.			
	1. DECEDENT'S NAME (First, Middle, Lest)	. 1							2. DATE OF		Y	YEAR	3. TIME OF DEATN
	Mary Elizabe		Allen						Octob		19	95	1:59 P M
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. lest		IF UNDER	DAYS.	HOURS	MIN.	?. DATE OF (Month, D	lev Weer)	8. BIRTNPLACE (State or For Country)		y)
	579-14-2816	73	YAS.	March				March	15,1	1922 Washington, I			
	9a. FACILITY NAME (If not institution, give s		9b. CITY,	TOWN	OR LOCATI	ON OF D	EATN		9c. COU	NTY OF DE	EATN		
RO	Holy Cross Hospit	al			Silver Spring Mon					ontgo	mery		
DIRECTOR	RESIDENCE OF DECEDENT												
믦	10a. STATE 10b. COUNTY		10c. CIT	Y, TOWN C	R LOCA	TION						10d. INSIDE CITY LIMITS?	
	Maryland Mont	gomery		S:	Silver Spring								1 YES 2 X NO
A	10e. STREET AND NUMBER	-	_			10	. ZIP COD	E			10g. CIT.	ZEN OF W	NAT COUNTRY?
FUNERAL	8703 Bradford Roa	ad					209	01				US	A
3	11. MARITAL STATUS	12. WAS DECEDENT							NIC ORIGIN?		or No	14. RACE	American Indian,
	1 Never Married 2 Married	FORCES? 1	YES 2 X N	0			ecify Cubi		an, Puarto Rici	en, etc.)		Specif	y White, atc.
84	3 Widowed 4 Divorced												White
COMPLETED	15. DECEDENT'S EDU				USUAL O				16b. K	IND OF BUS	INESS/IN	DUSTRY	
Ш	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+	Ma	Do NOT u	work done (se retired.)	uunng me	ISC OF WORK	ng					
4	12			ecret	tary				S	oft 1	Drink	с Соп	ipany
0	17. FATNER'S NAME (First, Middle, Last)					18. MOT	NER'S N	AME (First, Mid					
	Ambrose W. Healy	7					E	liza	beth M	L Kr	01		
8E	19a. INFORMANT'S NAME (Type/Print)		195	MAILING	ADDRESS	S (Street)			Route Number,			n Codel	
2	James R. Allen								ckvil1			0855	
								, RO		_			
	20a. METNOD OF DISPOSITION 1												
	21. SIGNATURE OF FACILITY 22. NAME AND ADDRESS OF FACILITY									Tilg, rib			
	21. Signil single galleting terminal	00								s Fur	era1	Hom	e, Inc.
	· Moberto	Man	isely.										.MD 20901
\neg	23. PART I. Enter the diseases, or				not enter								Approximate
	ahock, or heart fallure.	List only one cau	se on the line.										Interval Batween Onset and Death
- 1	IMMEDIATE CAUSE (Finel disease or condition	e PSIS										12 hours	
	resulting in desth)			PNSEQUENCE OF):									TOURS
_		_	•	er cancer									3 MONTHS
NO	Sequentially list conditions,		OR AS A CONSEC			CI							2 11001113
F	If any, leading to immediate cause. Enter UNDERLYING		,		,								
유	CAUSE (Disease or Injury	c. OUE TO	(OR AS A CONSEC	UENCE C	MF):								
CERTIFICATION	that initiated events resulting in death) LAST												
핑		d											
	PART II. Other algnificant condition	e contributing to	deeth but not re	eaulting	In the ur	nderlyin	g cause	given ir	n Part I. 2	4a. WAS AN		24b	WERE AUTOPSY FINDINGS
EDICAL										YES 2			COMPLETION OF CAUSE OF DEATN?
											(2)		1 YES 2 NO
2	DID TOBACCO USE CONT	PIRITE TO CA	LISE OF DEAT	TH Y	ES 🗍	NO F	7 LIN	CERTA	IN ID				, , , , , , , , , , , , , , , , , , , ,
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL	KIBOIL TO CA			TN (Check			CLIVIA	II V DEJ				
0	EXAMINER?	HOSPITAL:		-	OTHE	R:							
YS	1 TYES 2 NO	1 M Inpetient 2				-	-	lasidence	6 Other (
표	27. MANNER OF DEATN 1 Whatural 5 Pending	28a. DATE OF (Month, D		28b. Till IN	JURY	W	JURY AT ORK?		28d. DESC	RIBE NOW I	NJURY OC	CURED	
ВУ	2 Accident Investigation				М		YES 2	_ NO					
100	3 Suicide 6 Could not be	28a. PLACE O building,	F INJURY — At ho atc. (Specify)	me, farm,	street, fac	tory, offi	Ca			Town, State)		r or Rural I	Route Number,
	4 Nomicide determined												
PLE	29a. CERTIFIER 1 CERTIFYING PNYS	ICIAN: To the best of	my knowledge, da	ath occur	red at the	time, det	e and plac	e, and du	e to the cause	e(s) and me	nner aa sti	ited.	
COMPLETED	one) 2 MEDICAL EXAMINI	ER: On the basis of a	xemination and/or I	investigati	on, in my	opinion,	death occi	ured at th	ne time, date a	nd place, er	nd due to t	he cause(s	i) and menner se stated.
	29b, SIGNATURE AND TITLE OF CENTIFIE	745					29c. Li	CENSE N	UMBER		29d. DA	TE SIONEC	(Month, Day, Year)
BE	4	WWW					7	33	2407	7	•	101:	23/95
2	30. NAME AND AGORESS OF PERSON WIT	COMPLETED CAUS	SE OF DEATH (ITE	M 27) (7/0	e, Print)			70	/			'	
	JOSEPH M. HAGE					11	Col	Tre	he	Rnew	1110	MA	20850
	31, DATE EILED (Month, Day Year)			1 /	1601	C/1 C	C E 70	111	ρ	HOCK	A of the	17-10	200
	31. DATE EILED (Month, Day, Year) 26 1995	Julia Davels	ar's synature or largall										

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FOR

REGISTRAR

4. SOCIAL SECURITY NUMBER

1. DECEDENT'S NAME (First, Middle, Last)

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6. AGE (In yrs. lest birthday) APRIL 9, 146-18-7113 1 M 2 XF 71 YRS. Pages 1, 2, 3 should 9s. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION MARYLAND MONTGOMERY SILVER SPRING permit. FUNERAL 10e. STREET AND NUMBER 321 UNIVERSITY BLVD. W. #103 funeral director, page 5 should be detached for use as the burial-transit 20902 Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ASMED FORCES? 1 YES 2 ND 11. MARITAL STATUS 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea or No—If yea, specify Cuban, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify: BALTIMORE, MARYLAND 21215-0020 FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES 1 Never Merried 2 Married BY 3 🕅 Widowed 4 🗌 Divorced 50 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working 15. DECEDENT'S EDUCATION

(Specify only highest grade complete COMPLET (Give kind of work done life. Do NOT use retired.) ndary (0-12) College (1-4 or 5+) 12 HOUSEWIFE 17. FATNER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Meiden Surname) Ħ MORRIS WEINSTOCK MATILDA GOLDMAN BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 MARK HANNA (SON) 40 HOAGLAND DRIVE - BELLE MEAD, NEW JERSEY 08502 be 20s. METHOD OF DISPOSITION
1 X Burlel 2 Cremation 3 X Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of OATE must GREENWAY CEMETERY Donation 5 Other (Specify) 10/25 examiner 21. SIGNATURE OF SUNERAL SERVICE LICENSE ate be executed within 24 hours after death. ysician and completely filled in by the funera prior to burial, cremation, or removal. Wole. medical 23. PART t. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ahock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final 皇 disease or condition reaulting in death) traumatic event, CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate attending physician certificate be cause. Enter UNDERLYING CAUSE (Disease or Injury Hygiene p other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 10 the death has been signed by the atter Dept. of Health and Mental injury, MEDICAL requires that any Shows DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES | NO | PHYSICIAN: UNCERTAIN [WE 23 25. WAS CASE REFERRED TO MEDICAL The ltem! certificate State OTHER 1 TYES 2 DAG ATTENDING PHYSICIAN: Inpetient 2 - ER/Outpetient 3 - DOA ng Home 5 - Residence 6 - Other (Specify) the 0 27. MANNESPOF DEATH 28s. DATE OF INJURY 26b. TIME OF 28c. INJURY AT WORK? marked, With this T YES 2 NO BY death After 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, str. (%pec/ly) .09 3 Suicide 281. LOCATION (Greet and Number or Rural Route Number City or Years, State) # Could not be COMPLETED DIRECTOR: hours after 28 4 Homicks TO THE HOSPITAL OR ATT TO THE FUNERAL DIRECTI be filed within 72 hours at IMPORTANT: It Item 2 29a, CERTIFIER CERTIFYING PHYSICIAN ed at the time, date and place, and due to the councie; and manner as statut. 2 MEDICALLEYA URE AND TITLE OF BE 2 38. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF GEATH (ITEM 27) (Type, 6201 31, DATE FILED (Month, Day, Year)

CERTIFICATE OF DEATH

IF UNDER 1 YEAR

IF UNDER 24 HRS.

95 33600 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REG. NO. 2. DATE OF DEATN 3. TIME OF DEATH OCTOBER 22, 1995 10:40 A 7. DATE OF BIRTH B. BIRTHPLACE (State or Foreign PENNSYLVANIA 1924 9c. COUNTY OF DEATN MONTGOMERY 10d. INSIDE CITY 1 YES 2 NO 10g, CITIZEN OF WHAT COUNTRY? UNITED STATES 14. RACE - American indian, Black, White, etc. Specify: WHITE 16b, KIND OF BUSINESS/INDUSTRY OWN HOME 20c. LOCATION - City or Town, State BERKLEY SPRINGS, WV 22. NAME AND ADDRESS OF FACILITY DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE-ROCKVILLE, MD. 20852 Approximate Interval Betw Onset and Beat

> 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO PERFORMED? COMPLETION OF CAUSE 1 YES 2 NO

T YES 2 NO

38d, DESCRIBE HOW INJURY OCCURED

32. REGISTRAN'S SIGNATURE

26

DHMH-16 Rev 1/89

.

r attending physician. use as the burial-transit permit. Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for or	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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TO BE (

Ted E. Howe,

				95	33601					
	1 - FOR STATE OF MARYLA	ND / DEPARTMENT OF CERTIFICATE OF	HEALTH AND MENTA	L HYGIENE REG. NO.						
	1. DECEDENT'S NAME (First, Middle, Leat) Ella Louise Beard			OF DEATH	95 3. TIME OF OEATH 95 5:25 D M					
	4. SOCIAL SECURITY NUMBER 220-26-5101 1 □ M 2 ☒ F 63	yrs. last birthday) IF UNDER 1 YEAR MONTHS DAYS	IF IMPER 24 HRS 7 DATE	о г віятн h, <i>Day</i> , (bar) h 2, 1932	8. BIRTHPLACE (State or Foreign Country). Maryland					
N.	9a. FACILITY NAME (If not institution, give street and number) Williamsport Nursing Home	OR LOCATION OF DEATH	9c. COU	INTY OF DEATH hington						
DIRECTOR	Williamsport Nursing Home RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY	10c. CITY, TOWN OR LOCA	ATION		10d. INSIDE CITY					
	Maryland Washington 100. STREET AND NUMBER	Hagerst	Of. ZIP CODE		1 M YES 2 ☐ NO					
FUNERAL	11 W. Baltimore Street 11. MARITAL STATUS 12. WAS DECEDENT EVER IN 1 PORCES? 1 YES		21740 CENDENT OF HISPANIC ORIGIN	17 (Specify Yes or No —	SA 14. BACE — American Indian,					
B	3 Wildowed 4 Divorced IF YES, GIVE WAR OR DAT	TES 1 T YE	pecify Cuban, Maxican, Puerto S 2 NO Specify:		Black, White, etc. Specify: White					
once. COMPLETED	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPAT (Give kind of work done during m life. Do NOT use retired.) Office M	ost of working	Statton Fu						
COMF	12 17. FATHER'S NAME (First, Middle, Lest)	anager 18. MOTHER'S NAME (First,	Middle, Maiden Surname)							
TO BE	Roy Samuel Snyder	Catherine C and Number or Rural Route Num treet Hagers	e Cramer Butts oute Number, City or Town, State, Zip Code) gerstown, Maryland 21740							
e pe u	Pamela A. Harr 20a. METHOD OF DISPOSITION 1 Burlel 2 (XCremation 3 Removel from State	E 20c. LOCATION -	City or Town, State							
iner mu	21. DONATURE OF FUNERAL SERVICE LICENSEE Commerce									
са ехаш	23 PART I Enter the diseases or complications that according	Funer	al Home	Hagersto	own, Maryland					
ne medi	23. PART I. Enter the diseases, or complications that ceused is abock, or heart feilure. List only one ceuse on ask IMMEDIATE CAUSE (Final disease or condition	liac or reapiratory ar	Approximate Interval Between Onset and Death 5 Months							
event,	resulting in death) a. CEPEDTAT ME LAS LASES OUE TO (OR AS A CONSEQUENCE OF):									
RTIFICATION	Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING Bronchogenic Carcinoma 5 months DUE TO (OR AS A CONSEQUENCE OF):									
or other traumatic event, the medical examiner must be notified at once. ERTIFICATION TO BE COM	CAUSE (Disease or Injury thet initiated events resulting in death) LAST									
AL C	PART II. Other algnificant conditions contributing to death but	t not resulting in the underlying	g cause given in Part I.	24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO					
MED		NW.		1 □ YES ŽXXNO	OF DEATH? 1 YES 2 NO					
SICIAN:	DID TOBACCO USE CONTRIBUTE TO CAUSE OF 25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL:	B. PLACE OF DEATH (Check only one)								
ē `	1 YES 2 XNO 1 Inpatient 2 ER/Outpet 27. MANNER OF OEATH 280. DATE OF INJURY (Month, Day, Year)	lient 3 DOA 4 Nursing Hor 28b. TIME OF 28c. IN.	JURY AT 28d. OES	CRIBE HOW INJURY OC	CUREO					
ED BY PH	2 Accident Investigation 3 Suicide 8 Could not be building, etc. (Specify	- At home, farm, street, tactory, offic	YES 2 NO 28f. LOC City	ATION (Street and Number or Town, State)	r or Rurel Route Number,					
PLET	29a. CERTIFIER (Check only IXXCERTIFYING PHYSICIAN: To the best of my knowled	dge, death occurred at the time, dat			1ed.					
	2 MEDICAL EXAMINER: On the basis of examination of		death occured at the time, date	and place, and due to fi	he cause(a) and manner as stated.					
BE C	Otatione M		D33700		TE SIGNED (Month, Day, Year)					

PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

M. D. 18100 Slade School Road

Sandy Spring, Maryland

20860

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within and loan set of each. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

FOR STATE REGISTRAR 1.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

- 1	1. DECEDENT'S NAME (First, Middle, Last,	JOHN WA	YNE BI	ROWN			2. DATE OF	DEATH	WE AD	3. TIME OF DEATH	
	JOHN W BROWN						10	17	95	0946 M	
	4. SOCIAL SECURITY NUMBER	5. SEX 6.	AGE (In yrs. lesi		UNDER 1 YEAR		7. DATE OF E	BIRTH	8. BIRT	HPLACE (State or Foreign	
	243-72-5445	1 📉 M 2 🗆 F	48	B YRS. MOI	THE DAYS	B HOURS MIN.	12-19	-46	No	rth Carolina	
	9a, FACILITY NAME (If not institution, give	street end number)		96	CITY, TOW	N OR LOCATION OF D			COUNTY OF I		
DIRECTOR	PENINSULA REGIONA	CENTER	s	ALISB	URY	-	W:	ICOMIC	0		
JE C	10a. STATE 10b. COUN		10c. CITY, TO	OWN OR LO	CATION				10d. INSIDE CITY		
2	Maryland Wic		W	illar	ds	100			LIMITS? 1 YES 2 NO		
AL	10e. STREET AND NUMBER				101. ZIP CODE		10g	. CITIZEN OF	WHAT COUNTRY?		
FUNERAL	7020 Powellvil				21874	USA					
S	11. MARITAL STATUS	12. WAS DECEDENT E FORCES? 1	VER IN U.S. ARI	MED	13. WAS D	ECENDENT OF HISPA	NIC ORIGIN? (S	pecify Yes or N	0- 14. RAC	E — American Indien,	
ВУ Б	1 Never Married 2 Merried 3 Widowed 4 Divorced	OR DATES	10		specify Cuben, Maxico		1, etc.)	Spec			
			Guard		<u> </u>					WHITE	
COMPLETED	15. DECEDENT'S ED (Specify only highest grad	UCATION le completed)	(G/	Ve kind of work	done during	TION most of working	16b. KIN	D OF BUSINES	S/INDUSTRY		
J.	Elementary/Secondary (0-12)	College (1-4 or 5+)	100	Do NOT use re			Ch	h - D	7 *		
ME	12	3	P	olice	JIIIC			ate Po.			
S	17. FATHER'S NAME (First, Middle, Last)	D				18. MOTNER'S NA					
BE	John 19e. INFORMANT'S NAME (Type/Print)	Brown				Floren			Winber	ry	
2			198			et end Number or Rural				07/	
	Mary K. Brown					lville Rd					
	1 ☐ Burial 2X☐ Cremation 3 ☐ Rea	cametery, crei	ACE AND DATE OF DISPOSITION (Name of ty crematory or other piece) Lisbury Crematory				OATE 20c. LOCATION — City or Town, State				
	4 Donation 6 Other (Specify)	CENSFE	Sali	22. NAME AND ADDRESS OF FACILITY					Salisbury, MD		
	22. NAME AND ADDRESS OF FACILITY Holloway Funeral Home										
	March	17. (bo)	MODON	\supset	50	1 Snow Hi	11 Rd.	, Salis	sbury,	MD 21801	
	23. PART I. Enter the diseases, or shock, or heert fellure	complications that co. List only one cause	on each line	ath. Do not	enter the r	mode of dying, aud	ch aa cardlac	or reapirator	y arreat,	Approximate interval Between	
	IMMEDIATE CAUSE (Final		or oder mid	•						Onset and Death	
	disease or condition										
	OUE TO (OR AS A CONSEQUENCE OF):										
	and the second second				ARCTI	ON					
N					ARCTIO	ON_					
MOIT	Sequentially list conditions, if any, leading to immediate	OUE TO (OF		OUENCE OF):	ARCT'J.	ON					
ICATION	Sequentially list conditions,	DUE TO (OF	R AS A CONSEC	DUENCE OF):	ARCT'J.	ON					
MIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	DUE TO (OF	AS A CONSEC	DUENCE OF):	ARCTIO	ON					
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury	DUE TO (OF	R AS A CONSEC	DUENCE OF):	ARCITIO	ON					
AL CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	DUE TO (OF DUE TO (OF d.	R AS A CONSEC	DUENCE OF):			Pert I. 24s	ı. WAS AN AUTO		b. WERE AUTOPSY FINDINGS	
	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OF DUE TO (OF d.	R AS A CONSEC	DUENCE OF):			-3	PERFORMEO	,	AMILABLE PRIOR TO COMPLETION OF CAUSE	
	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OF DUE TO (OF d.	R AS A CONSEC	DUENCE OF):			-3		,	AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATN?	
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DIVISION OF VITAL RECORDS, P.O. BOX 68760.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, case 5 should be described for uses as the huntal-trans-

1	FOR STATE REGISTRAR	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL CERTIFICATE OF DEATH	HYGIENE REG. NO.

					- Call 1111	TIOA	L. 01	DEATH	- T	HEG. NO).		
	1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH DAY									DAY	YEAR	3. TIME OF DEATH	
	Harriett 4. SOCIAL SECURITY NUMBER		ckhead 5. SEX						Oct	.12	190		9:20 A M
			5. SEX		yrs. lest birthde	MONTH	B DAYS		(Month,	Day, Year)		Countr	PLACE (State or Foreign y)
	218-20-72			93	YRS				May	, 28	1902	Mar	yland
œ		9e. FACILITY NAME (If not institution, give street end number)						OR LOCATION OF	DEATH		9c. COU	NTY OF D	EATH
2	Salisbury Nu	Salisbury Nursing & Rehab Center				Sal	.isbı	ry, Md.	2180	1	Wic	comic	0
DIRECTOR	10e. STATE	10b. COUNTY			10c. (CITY, TOWN	OR LOC	ATION				T	10d. INSIDE CITY
5	Maryland Wicomico				Sa1	Salisbury						LIMITS?	
AL DIRECT	10e. STREET AND NUMBER			Dul		IOI. ZIP CODE			10g. CITI	ZEN OF W	HAT COUNTRY?		
FUNERAL	1009 N.Division Street 21801 U.S.A												
5	11. MARITAL STATUS	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ABMED				1:	3. WAS DE	ECENDENT OF HIS	PANIC ORIGINS	(Specify Ye		14. RACE	- American Indian.
BY F	1 Never Married 2 3 Widowed 4 Divo	1 Never Married 2 Merried FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES						S 2 NO Spi		ican, etc.)	I	Speci	ly:
											1		Black
E E		EDENT'S EDUC highest grade		1	6a. DECEDENT	of work don	e during n	TION nost of working	16b.	KIND OF BU	ISINESS/IND	USTRY	
2	and the same of th	Elementary/Secondary (0-12) College (1-4 or 5+)				use retired	,			220-00-00			
once. COMPLET	1.2 17. FATHER'S NAME (First, M.	(della 1 - et)			Domestic				None				
45						18. MOTNER'S NAME (First, MI							
	George Birckhead 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, Stete, Zip Code)												
TO BE													
2	John Birc							42 Sal	isbur				
must	20b. METNOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of cometery, crametory or other place) 20b. PLACE AND DATE OF DISPOSITION (Name of cometery, crametory or other place)												
	4 Donation 5 Other (Specify) Green Acres 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY 23. NAME AND ADDRESS OF FACILITY												
examiner	Nug 1				4-					Home	P .		
	Stewart Funeral Home 821 West Rd.Salisbury, Md. 218 23. PART I. Enter the dylesses, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,											801	
or removal.	23. PART I. Enter the di ahock, or h	leases, or c	omplications the	t caused ti	ha death. De	not ente	er the m	oda of dying, s	uch as cardi	ac or resp	iratory arr	eat,	Approximate
	IMMEDIATE CAUSE (Fin						_						Onset and Death
cremation,	disease or condition - a unquer Destil, Suspect CM - Zomin												
event,	disease or condition resulting in death) a. Support Destri, Suspect CM To min DUE TO (OR AS A CONSEQUENCE OF): ATHERE Support ATHERE Support To min												
	Sequentially list conditions												
traumatic	If any, leading to immediate cause. Enter UNDERLYING												
a . 1 U	CAUSE (Disease or Injury 5 c.												
other TTIFIC	that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST												
E S E		d	l							-			
0 =	PART II. Other algorificent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS												
eaith and M	Demer	2713		AD	MMC	20 Aug				PERFORMED? AVAILABLE		AVAILABLE PRIOR TO COMPLETION OF CAUSE	
	HITO		Lluc	₹57H	grow	1				I U YES	DENO		OF DEATH?
sho I	DID TOBACCO US	SE CONTR	IBUTE TO CA	USE OF	DEATH '	∕ES □	NO 5	KT UNCERTA	IN D				1 TYES 24 NO
State Dept.	25. WAS CASE REFERRED TO				PLACE OF DE				111				
State C	EXAMINER?		HOSPITAL:	ER/Outpatk	ent 3 🗆 DOA	OTHE	ER:	me 5 🗆 Resident	a & C Other	(Specific)			
s marked, or BY PHY	27. MANNER OF DEATN		28e. DATE OF	INJURY	28b. T	IME OF	28c. IN	JURY AT			INJURY OCC	URED	
marked, BY PH	<u> </u>	Pending rivestigation	(Month, D	ey, Year)	- 1 "	NJURY M		YES 2 NO					
E B D	2 Dulelde	Could not be	28e, PLACE O	F INJURY	At home, fain	, street, fa	ctory, off	ce			and Number	or Rural R	oute Number,
E oo III		letermined	bollonig,	etc. (Specify)	,				City or	Town, Stete			
Item Item	290. CERTIFIER	FYING PHYSIC	CIAN: To the best of	my knowled	ne death occu	grad at the	time det	e and alone and d	us to the same	-4-1 4	u de de		
ANT: If Ite													end menner es stated.
	29b. SIGNATURE AND TITLE						ориноп,			mo prace, si			
POR B	290, SIGNATURE AND TITLE	1	411	\sim				29c. LICENSE N	UMBER		29d. DATE	SIGNED	(Month, Day, Ybar)
2 ₹ 2	30 NAME AND ADDRESS OF		- ME			10398B 10/12/22					2/22		
	30. NAME AND ADDRESS OF						TC.778 T T	DDTIF	037	DI	345	03.5	201
	31. DATE FILED (Month, Day,)	47K/					1WAY	DRIVE,	SALIS	ROKY,	MD.	218	SUI
5		3 1995	32. PEGISTRA	auction	- Rardall								
2		9 1000											

X × ×

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 23 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

		1. DECEDENT'S NAME (First, Middle, Last)	500AD 105				F DEATH	REG. NO),	I	TIME OF OEATN
		EDGTAR	EDGAR LO	JACOB,	<u>pg</u> ks				AY	YEAR 3.	A: FEA M
		4. SOCIAL SECURITY NUMBER 212-09-8196	5. SEX 6. AC	80 (In yrs. last		IF UNDER 1 YEA	1 1	7. DATE OF BIRTH (Month, Day, Year)		8. BIRTNPL/ Country)	ACE (State or Foreign
		9e. FACILITY NAME (If not institution, give street end number)				9b. CITY, TOWN OR LOCATION OF DEATN				Mary I	
	OR	John Deaton Medical Center					timore			imore	
	DIRECTOR	RESIDENCE OF DECEDENT									
	DIR	MD Anne	Arundel			TY, TOWN OR LOCATION Annapolis					d. INSIDE CITY LIMITS? YES XX NO
	FUNERAL	10e. STREET AND NUMBER					101. ZIP CODE		10g. CITIZ	ZEN OF WHA	
	NEF	2603 Point Looko	ut Cove				21401			ted S	
		1 Never Married 2 Merried	R IN U.S. ARN ES 2 NO R DATES	NED	If yes,	specify Cuben, Mexic		s or No-	Black, W		
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te pe	BE	Edgar L. Brooks 190. INFORMANT'S NAME (Type/Print) 190. MAILIN						ephine Sto			
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st be		20e. METNOD OF DISPOSITION 1 Burial 2 Cremetion 3 Rem	1:	20b. PLACE A	ND DATE OF	DISPOSITION	(Name of	DATE 20c, LC	CATION - C	Sity or Town.	State
er must		4 Donation 8 Other (Specify)	-0	i nco i	of n Crematory 10/31/95 Brentwood, Maryland 22. NAME AND ADDRESS OF FACILITY Ohn M. Taylor Funeral Home						
or removal. medical examiner	•	21. SIGNATURE OF FUNERAL SERVICE U	CENSEE	//		22. NAME	AND ADDRESS OF FA	will yohn M.	Taylo	r Fun	eral Home
oval.		147 Duke of Gloucester St. Anna 18. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,									
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Health and Mental Hygiene prior to burial, cremation, ws any injury, or other traumatic event, the		reasting in death)	DUE TO (OR A	S A CONSEC	UENCE OF)						104-3
natic natic	ON	Sequentially list conditions, If any, leading to immediate. Due to (or as a consequence of):									
traur traur	CATION	cause. Enter UNDERLYING CAUSE (Disease or Injury									
Hygiene prior to burial, cremation, or other traumatic event, the	RTIFI	that initiated events resulting in desth) LAST DUE TO (OR AS A CONSEQUENCE OF): d. MY I HAVE LEGAL TO SECUENCE									
ry, or	CER										
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State Dept item 23	IAN	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)									
or ite	YSICI	1 YES 2 NO	HOSPITAL: 1 Temperiant 2 ER/O	utpatient 3		OTHER:	ome 5 - Residence	8 Other (Specify)			
	표	27. MANNER OF DEATH 1 Natural 5 Pending	28e. DATE OF INJUR (Month, Day, Year		28b. TIME INJUI	RY .	NJURY AT WORK?	28d. DESCRIBE NOW	NJURY OCC	URED	
is marked	BY	2 Accident Investigation 3 Suicide 6 Could not be	28s. PLACE OF INJU	RY — At hom	ie, ferm, str	, ,	YES 2 NO	28f. LOCATION (Street	and Number of	or Rural Route	Number
3 afte	ETEC	4 Homicide determined	building, atc. (S	pecify)				City or Town, State,			
22 23	COMPLE		CIAN: To the best of my kn								manner as stated.
be filed within	w	2 MEDICAL EXAMINER: On the basic of examination end/or investigation 29b. SIGNATURE AND TILLE OF CERTIFIER					29c. LICENSE NUI				nth, Day, Year)
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		30. NAME AND ADDRESS OF PERSON WH	2-1 aux	DEATH (ITEM	27) (Type, P	rint)	as Ro	IKMD o	100	a	
		31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SI	GNATURE		U /	re or		120	1	
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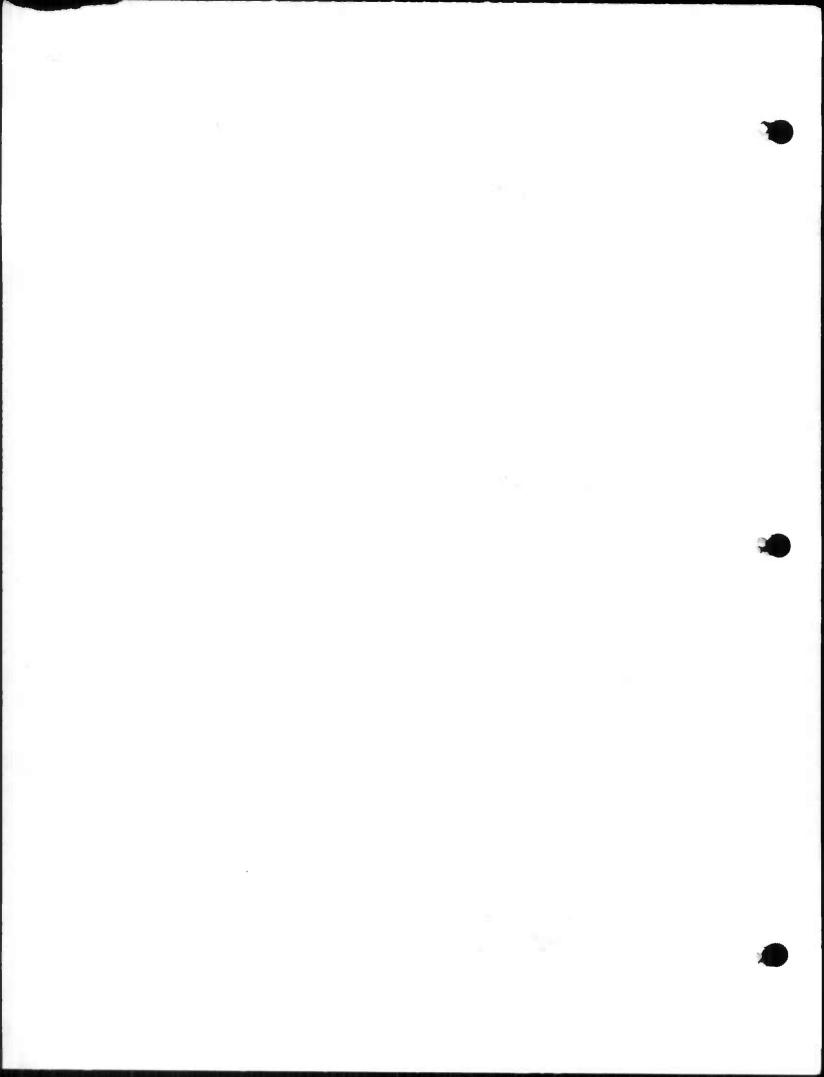
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH REG. NO 11995 05:45 AM 2. DATE OF DEATH 1 DECEDENT'S NAME (First Middle Last) **™**26th "OUT. BROWN HENRIETTA 7. DATE OF BIRTH 8 BIRTHPI ACE (State or Forming 4 SOCIAL SECURITY NUMBER 5 SEY 6 AGE (In ure last hirthday) IF UNDER 1 YEAR IF LINDER 24 HRS. (Month, Day, Year) APRTL 7 1918 MONTHS DAYS HOURS MARYLAND 1 M 2 F 77 212-26-8193 Sa. FACILITY NAME (If not institution, give street and number, 9c. COUNTY OF DEATH 9b. CITY TOWN OR LOCATION OF GEATH A.A. COUNTY NORTH ARUNDEL HOSPITAL ASSOCIATION GLEN BURNIE DIRECTOR 10b. COUNTY 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? 1 X YES 2 NO ANNAPOLIS ANNE ARUNDEL MARYLAND 10e. STREET AND NUMBER 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? FUNERAL USA 21401 1810 ROBERTSMALL ROAD 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, atc. It yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 X Never Married 2 Married 1 TYES ZX X NO Specify: Specify: BY 3 Widowed 4 Divorced BLACK ETED. 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use relired.) 15. DECEDENT'S EDUCATION Elementary/Secondary (0-12) College (1-4 or 5 +) COMPL SOME ONE ELSE HOME 9th DOMESTIC 0 once. 17, FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malden Surname) 76 MARY E. TAYLOR BENJAMIN BROWN notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING AODRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 104 CASTLETON DRIVE UPPER MARLBORO, MD. 20772 PEARL GANTT 9 20a. METHOD OF DISPOSITION DATE 20c. LOCATION - City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of must Burial 2 Cremation 3 Removal from State HOPE" ST. MARK CHURCH CEME. 10/31/95 EDGEWATER, MD. Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE examiner REESE & SONS MORTUARY, P.A. eese arri X 821 WEST ST. ANNAPOLIS , MD. 21401 medicai 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate shock, or heart fellure. List only one ceuse on each line. Interval Between Onset and Death IMMEDIATE CAUSE (Finel other traumatic event, the disesse or condition ASPITATION /NO DUE TO (OR AS A CONSEQUENCE OF): 2 hour Preumonia resulting in death) CERTIFICATION Sequantistly list conditiona, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury OUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 10 injury, PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL PERFORMED? AVAILABLE PRIOR TO Domintio эшу U-Ces COMPLETION OF CAUSE 18phareu 1 - YES 2 NO shows a Surve Austolis t TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 23 26. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL Hem HOSPITAL 1 - YES 2 - NO Inpetient 2 DER/Outpetient 3 DOA 4 - Nursing Home 5 - Residence 6 - Other (Specify) 0 28c. INJURY AT WORK? 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28d. DESCRIBE HOW INJURY OCCURED marked, 1 Netural 5 Pending Investigation BY 2 Accident 28s. PLACE OF INJURY — At home, term, street, factory, office building, atc. (Specify) 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 60 6 Could not be COMPLETED 28 4 Homicide Hell 29a. CERTIFIER
1 Chack and
1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and menner as stated. = 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated. TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: 1 29c. LICENSE NUMBER 29d. DATE SJGNED (Month, Day, Year) BE 26 D38958 -c/m MD D 101 95 9 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) SIDHU, M.D./1413 ANNAPOLIS ROAD, #106/ODENTON, MARYLAND 21113 DALJEET S. 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE Sin Dhuilson Randall



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	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or :	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for us
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Brown Iris October 1995 3: 291 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH IF UNDER 24 HRS. a. BIRTHPLACE (State or Foreit HOURS 1 M 2 F 218-24-3919 YRS 7 N JULY 21 1925 MARYLAND 9s. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR GREATER LAUREL BELTSVILLE HOSPITAL LAUREL PRINCE GEORGE RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d, INSIDE CITY MARYLAND PRINCE GEORGE LAUREL 1 X YES 2 NO FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 11713 SOUTH LAUREL DRIVE, APT. 1611A 20708 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WILS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, stc. 1 Never Married 2 Married 1 YES 2 NO Specify: BY 3 Widowed 4 Divorced Specify: WHITE COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Spe Elementary/Secondary (0-12) College (1-4 or 5+) 11 HOUSEWIFE OWN HOME 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Meiden Surname) ARTHUR LIVINGSTON BE LILA MILLS 19s. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20708 2 BRENDA BACON 11723 SOUTH LAUREL DRIVE, APT. 512, LAUREL 20s. METHOD OF DISPOSITION

1 Burist 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State BEECHWOOD CEMETERY 4 Donetion 5 Other (Specify) 10/26 PRINCESS ANNE. 21. SIGNATURE OF FUNERAL SERVICE LIGHT 22. NAME AND ADDRESS OF FACILITY HINMAN FUNERAL HOME M00295 PRINCESS ANNE. MD. 21853 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. interval Between IMMEDIATE CAUSE (Final Onset and Death disease or condition MYDCARDIN INFARCTION reaulting in death) MINUTES DUE TO (OR AS A CONSEQUENCE OF) MAMASIA CERTIFICATION YEARS Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate cause. Enter UNDERLYING CEREBROVASCULAR CHTHOM CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events reaulting in death) LAST PART II. Other aignificant conditions contributing to deeth but not resulting in the underlying ceuse given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO MEDICAL GASTROINTESTINE BLEED COMPLETION OF CAUSE 1 | YES 2 | NOT OF DEATH? DIABRITES MELLITUR 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATH (Check only one) HOSPITAL: 1 YES 2 MO 1 | Inpetient 2 | ER/Outpetient 3 | DOA 4 Nursing Home 5 Residence 8 Other (Specify) 27. MANNER OF DEATH 28s. DATE OF INJURY 28b. TIME OF 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED 1 Natural INJURY 5 Pending 1 YES 2 NO В Investigation 2 Accident 28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) 3 Suicide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 4 Homtcide 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and menner as stated. 2 __ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner se stated. 29h. SIGNATURE AND TITLE OF CERTIFIE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE D4357S صلع was an 014 24 95

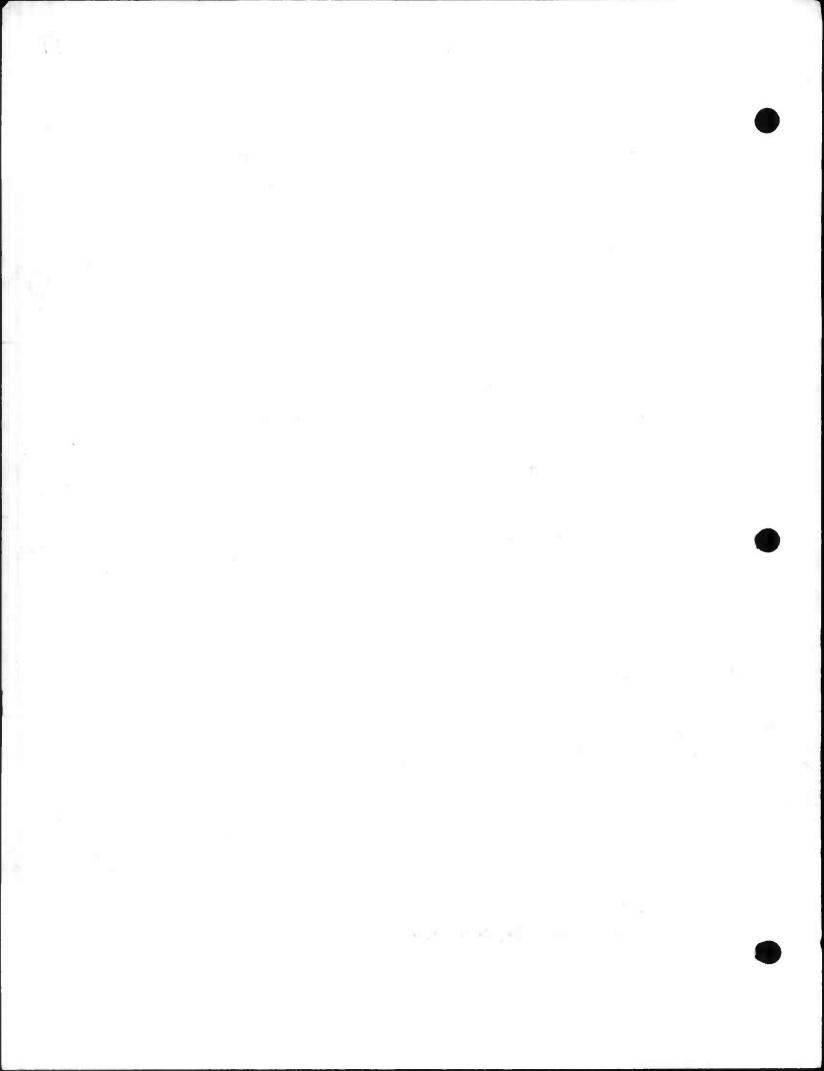
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FOR STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF OFATH 3. TIME OF DEATH Mary Brown 4.20 10 3 95 A SOCIAL SECURITY NUMBER 5. SEX 7. DATE OF BIRTH IF UNDER 1 YEAR | IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign May 20 1907 219-05-5690 88 1 🗌 M 2 👽 F Maryland permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH Sc. COUNTY OF GEATH Dorchester General Hospital DIRECTOR Cambridge Dorchester RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT 18c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Dorchester Cambridge 1 YES 2 | NO 10e. STREET AND NUMBER FUNERAL 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 520 Glenburn Ave. funeral director, page 5 should be detached for use as the burial-transit 21613 U.S.A. hours after death. Page 6 may be retained by the hospital or attending physician, 11 MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMEO FORCES? 1 ☐ YES 2 ☒ NO IF YES, OIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian, Black, White, etc. BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 Married If yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 TES AND Specify BY 3 ▼ Widowed 4 ☐ Divorced Specify: white ED | 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b, KIND OF BUSINESS/INQUSTRY (Specify COMPLET College (1-4 or 6+) 8 nurses aide state mental hospital 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Thomas A. Brown 76 Estelle Travers BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1905 Hambrook Blvd. Cambridge MD 21613 2 Mrs. Peggy Shenton must be 20a. METHOD OF DISPOSITION
1∑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE Dorchester Memo<u>rial Park</u> 4 Donation 5 Other (Specify) . 10/26 Cambridge Maryland examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY
Thomas Funeral Home 700 Locust St. Cambridge MD 21613 signed by the attending physician and completely filled in by the Health and Mental Hygiene prior to burial, cremation, or removal. the medical 23. PART I. Enter the diseases, or complications that caused the wath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata shock, or heart failure. List only one cause on each ill Interval Between IMMEDIATE CAUSE (Final Onset and Death diseese or condition resulting in death) neumonia event, days the death certificate be executed with. DIVISION OF VITAL RECORDS, P.O. BOX 68760 DUE TO (OR AS A CONSEQUENCE OF): traumatic NO Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CERTIFICAT CAUSE (Disease or injury other that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST 6 PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE MEDICAL 24s. WAS AN AUTOPSY Paul shows any 1 TYES 2 NO OF DEATH? 1 | YES 2 | NO peen to DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: DR ATTENDING PHYSICIAN: The law has b 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) certificate I HOSPITAL OTHER:
4 Nursing Home 5 Residence 6 Other (Specify) 1 TES 2 NO Inpatiant 2 - ER/Outpatiant 3 - DOA 6 27. MANNER OF DEATH 28b. TIME OF this c 26a. DATE OF INJURY 26c. INJURY AT 26d. DESCRIBE NOW INJURY OCCURED marked. 1 Natural 2 Accident 5 Pending BY 1 YES 2 NO After Investigation 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. PLACE OF tNJURY — At home, farm, street, factory, office building, etc. (Specify) 28 Is 6 Could not be DIRECTOR: / COMPLETED 4 Homicide If item 29a. CERTIFIER CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. TO THE HOSPITAL IN TO THE FUNERAL D be filed within 72 hr basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the ceuse(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE 29d. DATE SIONED (Month, Day, Year) 143 95 49 23 æeman 0 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Eyup Tanman, M.D. 15 Franklin Street Cambridge, MD 21613 31. DATE FILED (Morith, Day, Year) 1995 32 MEGISTRAR'S BIGNATURE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

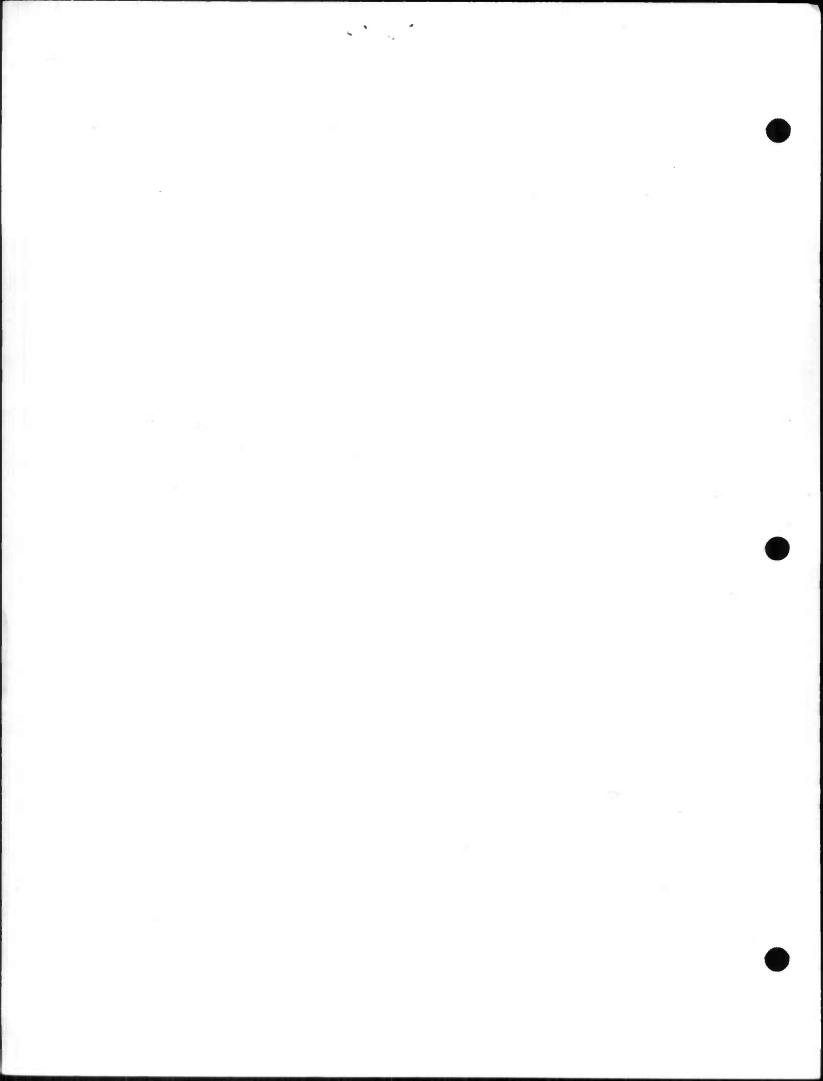


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	4. SOCIAL SECURITY NUMBER		E (In yrs. last birthda		IF UNDER 24 HRS.	7. DATE OF BIRTN		BIRTNPLACE (State or				
		ty⊡xM 2 □ F	22 YRS	MONTHS DAYS	HOURS MIN.	(Month, Day, Year,		Country)				
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ı	RESIDENCE OF DECEDENT											
: 1	10a. STATE 10b. COUN	TY	10c.	CITY, TOWN OR LOCA	ATION			10d. INSIDE CI LIMITS?				
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	10e. STREET AND NUMBER			1	or, ZIP CODE		10g. CITIZEN	OF WHAT COUNTRY				
	2416 Gibson Ro	ad			21050		11.5	5.A.				
	11. MARITAL STATUS	12. WAS DECEOENT EVER	IN U.S. ARMED	13, WAS DE		NIC ORIGIN? (Specify		RACE — American In				
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- 11	3 Widowed 4 Divorced	IF TES, GIVE WITH ON	DATES	1 1 1 16	S 2 NO Speci	ry:		Specify: Vhite				
15. DECEDENT'S EDUCATION 160. DECEDENT'S USUAL OCCUPATION 160. KIND OF BUSINESS/INDUS												
H	(Specify only highest grad	de completed)	(Give kind	of work done during n T use retired.)	nost of working	100. KIND OF	BOSINESS/INDOS	n.				
П	Elementery/Secondary (0-12)	College (1-4 or 5+)	Cook	230 1011100.)		Dooto						
ı	12	Resta										
17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surneme)												
l	Gordon Born		Joyce	Annette	Heizer							
	19e. INFORMANT'S NAME (Type/Print)	Town, State, Zip Co.	de)									
ł	Mrs. Joyce A.	Born	241	6 Gibson	Road, F	orest Hil	1. Marv	land 2105				
	20e. METHOD OF DISPOSITION			TE OF DISPOSITION (LOCATION — City					
1	1 GBurial 2 Cremetion 3 Re					_ 10/24						
1 General 2 Cremetton 3 Ramoval from Stata Camelery, cremetory or other place Churchville Presbyterian Cent. Churchville Churc												
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Tarring—Cargo Funeral Home, P.A.												
:	Aberdeen, Maryland 21001-3399											
23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approxim												
l	shock or haert fallura	. List only one cause on	aach Ilna.	o not emer the m	ioue or dying, su	cit as cardiac of ta	apriatory arreat	Interval				
ı	IMMEDIATE CAUSE (Final disease or condition											
	disease or condition a. W. ARG TMUNUS											
	DUE TO (OR AS A CONSEQUENCE OF):											
	Sequentially list conditions, If any leading to immediate DUE TO (OR AS A CONSEQUENCE OF):											
	If any, leading to immediate cause. Enter UNDERLYING											
	CAUSE (Disease or Injury that Initiated events Due to (or as a consequence of):											
2	resulting in death) LAST											
CENTIFICATION		0.										
	PART II. Other significant condition	ons contributing to death	but not resulting	ng in the undarlyl	ng causa givan ir		AN AUTOPSY	24b. WERE AUTOPS				
							FORMED?	AVAILABLE PRICOMPLETION O				
						I YES	2 NO	DF DEATH?				
	DID TODA CCO LIST CON	TOIDLITE TO CALLE	OF DEATH	VEC [] NO	- INICEPTAL			1 9 YES 2 [
	DID TOBACCO USE CON	IKIBUTE TO CAUSE			UNCERTA	ип						
	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF D	OTHER:	9)							
- 1	XXXES 2 NO	1 Inpatient 2X ER/O	utpatient 3 🗆 DO		me 5 🗆 Raeldence	6 Other (Specify)						
	27. MANNER OF DEATH	28e. DATE OF INJURY (Month, Day, Year,			NJURY AT YORK?	28d, DESCRIBE HO	W INJURY OCCUR	ED,				
	1 Natural 5 Pending	(1) 2 : 6	V 23		YES 2 NO	DRIVER	OFVEH	CLE POUNT				
	a Devices	28s. PLACE OF INJUI	RY — At home, fan	m, street, fectory, off	lice	281. LOCATION (Str.	eet and Number or	000				
	4 Homicide detarmined building etc. (Specify)						ete)					
		401	200017			INVALENCE L	richthas	reour to				
COMPLEIED		SICIAN: To the best of my kno	owledge, death occ	urred at the time, da	te end place, and du	e to the cause(e) end	menner ea stated.					
	one) 2 MEDICAL EXAMI	NER: On the basis of examinat	tion end/or inveatig	ation, in my opinion,	death occured at th	e ilme, date end placa	, end due to the c	nuse(e) end menner e				
	\$96,/SIGNATURE AND TITLE OF CERTIFI	ER A			29c, LICENSE NU	MOED	204 DATE S	GNED (Month, Day, Ye				
ı	War To	1 11 10 -										
	30. NAME AND ADDRESS OF PERSON W	June			OCM	E	00	T.22,19				
		HO COMPLETED CAUSE OF I	DEATH (ITEM 27) (7	ype, Print)								
	JU. NAME AND ADDRESS OF PERSON W	10.0										
2	MARLARIA A	KONELL M		Penn St	reet, B	altimore	, Marv	land 21				

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

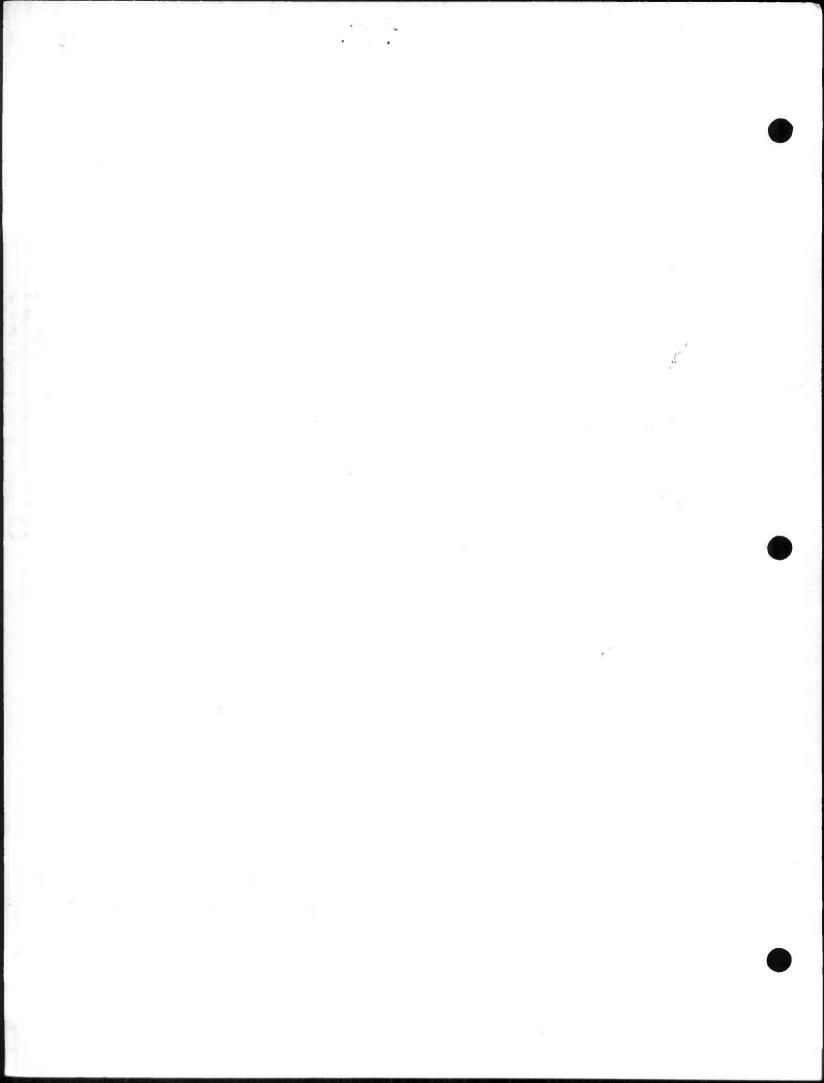
DHMH-16 Rev 1/89



DHMH-18 Rev 1/89

NDING PHYSICIAN: The law requires that the	be fined within 72 hours after oeath with the state begin of bealth and mental hyperic prior to build, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
--	--

	FOR STATE REGISTRAR	STATE OF MARY	LAND / DEPAR CERTIFI	TMENT OF I	EALTH AND I		YGIENE EG. NO.					
3	1. DECEDENT'S NAME (First, Middle, Last) BROCK	S.		BURKE		2. DATE OF D MONTH OCTOE	DAY	YEAR 199	3. TIME OF DEATH 07:20 PM			
8	4. SOCIAL SECURITY NUMBER 2/4-3/-459/ 9a. FACILITY NAME (If not institution, give st	1 M 2 □ F	E (In yrs. last birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS 9b. CITY, TOWN	F UNDER 24 HRS. HOURS MIN. OR LOCATION OF DI	7. DATE OF BI	18TH (Year) 24,/99		HPLACE (State or Foreign			
TOR	JOHN HOPKINS H	IOSPITAL		BALTIN	MORE	E						
DIRECTOR	MD HAR	FORD		VRE d		e,			tod. INSIDE CITY LIMITS? 1 YES 2 NO			
FUNERAL	8/6 N. Adams St. 21078 109. CITIZEN O											
BY	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? t YE: IF YES, GIVE WAR OR	S 2 NO	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No— If yea, specify Cuban, Maxican, Puerto Rican, etc.) 1 YES 2 NO Specify: NO Specify: Specify: Specify: NO Specify:								
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4 or 5 +) 18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 18b. KIND OF BUSINESS/INDUSTRY											
BE CON	17. FATHER'S NAME (First, Migdio, Leat), / EARNEST HAWKIKS 18. MOTHER'S NAME (First, Middle, Meiden Surneme) Belinda Burke											
5	190. INFORMANT'S NAME (Type/Print) 190. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) EARNEST HAWKINS 8/6 N. ADAMS ST. HAUrede Grace MD											
	20a, METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) 3 AMI 25 Cem 10-23 HAUVE Se Grade, MO											
	22. NAME AND ADDRESS OF EACHLITY BEARD FUNERAL HOME 552 Cewis 57. HDG. MD											
	23. PART I. Enter the diseases, or complications that caused the daeth. Do not enter the mode of dying, such as cardisc or respiratory arrest, shock, or heart fellure. List only one ceuse on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) Due TO (OR AS A CONSEQUENCE OF):											
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST											
PHYSICIAN: MEDICAL C	PART II. Other significent condition	s contributing to deeth	but not resulting i	in the underlying	g ceuse given in	18	PERFORMED?		b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?			
N.	DID TOBACCO USE CONT	RIBUTE TO CAUSE				N D P	sans	6	1 YES 2 NO			
SICIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 X YES 2 NO	HOSPITAL:	26. PLACE OF DEAT	OTHER:	ne 5 🗆 Raaldenca	8 Other (So	acity)					
PHY	27. MANNER OF DEATH	28a. DATE OF INJUR (Month, Day, Year	Y 28b. TIM	E OF 28c. IN	JURY AT	28d. DESCRIE	BE HOW INJURY		10. A			
D BY	2 Accident Investigation 3 Suicide 8 Could not be		RY — At home, farm, a	* 1		28f. LOCATIO	N (Street and Nur wn, State)		ROUTE Number,			
ETE	4 Homicide detarmined	PODD	WAY			MINNO	AST H		onn co un			
COMPLETED	(Check only	ICIAN: To the beat of my known. ER: On the beale of examinating							(a) and manner as stated.			
BE	29b. SIGNATURE AND TITLE OF CERTIFIES	The			29c. LICENSE NU			DATE SIGNE	D (Month, Day, Year) R 17 1995			
2	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUSE OF	DEATH (ITEM 27) (Type, 1111 P	enn St	reet, B	altimo	ore, M	aryl	and 21201			
	31. DATE FILE (COUT), DEV. (COT) 1995	32/REGISTRAR'S EN	GNATURS CON-ROYALL	· · · · · · · · · · · · · · · · · · ·								



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL URECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after each with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. MIPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumantic event the market he analytical as once.

Louis Kaufman

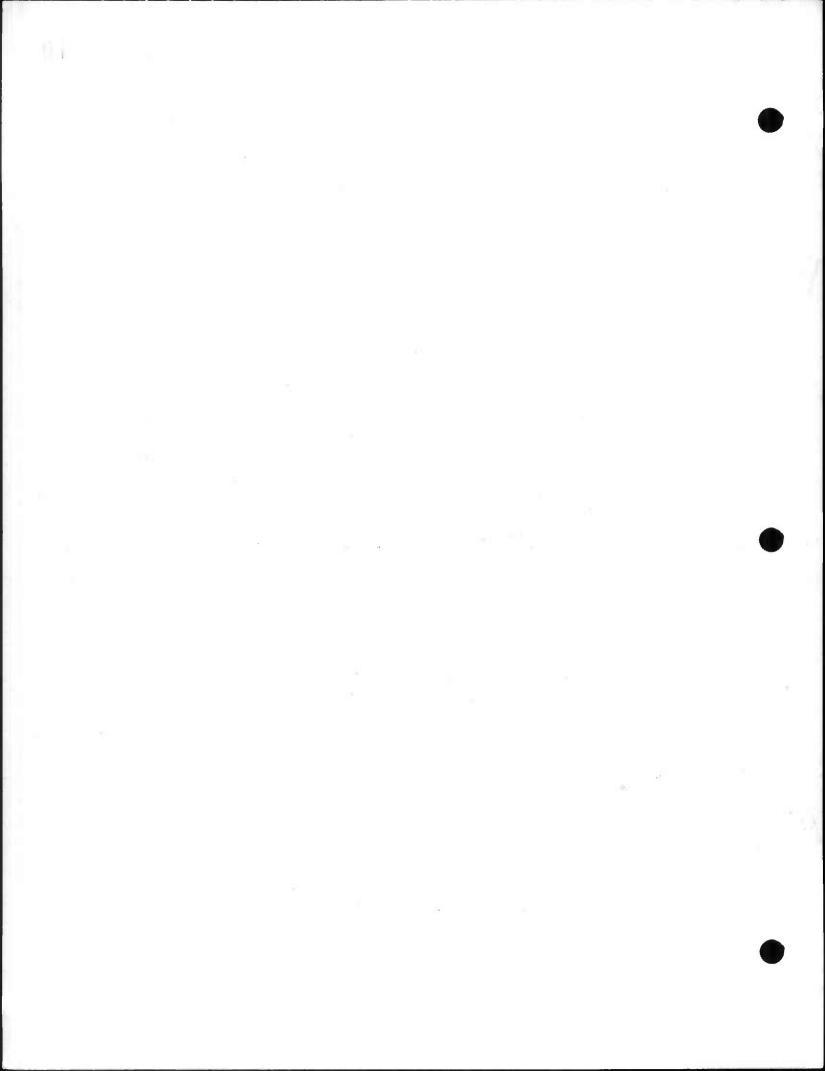
31. DATE FILED (Month, Day, Year) 1995

										9	5	33610		
	1 - STATE REGISTRAR	STATE OF M					EALTH A		MENTAL HYGIEN	Ε				
	1. DECEDENT'S NAME (First, Middle, Last)								2. DATE OF DEATH			3. TIME OF DEATH		
	Phyllis	Byrne						K	October "	27 :	1995	6:10p) M	
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. la	st birthday)	IF UND	R t YEAR	IF UNDER 2	4 HRS.	7. DATE OF BIRTH		8. BIRTH	PLACE (State or Foreign		
	306-30-3614	1 🗆 M 2 🖾 F	80	YRS.	MONTHS	DAYS	HOURS	MIN.	(Month, Day, Year) May 4, 191					
	9a. FACILITY NAME (If not institution, give a	treet and number)			96. CIT	Y, TOWN C	R LOCATION				INTY OF D		a	
8	Southern Maryla	nd Hann	4447 0			Cli	nton			Pri	ace i	Georges		
5	Southern Mary la		ITAL C	_						Prince Georges				
DIRECTOR	10a. STATE 10b. COUNT			10c. CIT	Y, TOWN	OR LOCAT	ION					10d. INSIDE CITY LIMITS?		
	Maryland Ch	arles			Indi	an H						1 X YES 2 NO		
RAI						101	ZIP CODE				HAT COUNTRY?			
FUNERAL	2 Oak Road		2064	_			.S.A.							
E	11. MARITAL STATUS 1 Never Married 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13.						ENDENT OF	HISPANII Maxican	C ORIGIN? (Specify Yes , Puerto Rican, etc.)	or No-	14. RACE Black	- American Indian, White, etc.		
BY							2/1 NO	Specify:			Specif			
0	15. DECEDENT'S EDUCATION 16a DECEDENT'S LISUAL OCCUPATION 16a MINO							16b. KIND OF BUS	INECCIA	DIETBY	White			
E	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4 or 5 +	(G	ive kind of a	work done	during mo	st of working		Tool Killo Or Boo	MILOSIM	DOSTRI			
P	12	College (I-4 of 3 T		mema.	ker				Her	Home	е			
COMPLET	17. FATHER'S NAME (First, Middle, Last)						18. MOTHE	R'S NAM	E (First, Middle, Malden	Sumame)	_			
BE C	Arthur Nestor							arie						
	19e. INFORMANT'S NAME (Type/Print)		19	b. MAILING	ADORES	SS (Street a	nd Number o	r Rural Ro	oute Number, City or Town	n, State, Zi	p Code)			
5	James L. Byrne					#10								
	20s. METHOD OF DISPOSITION 1 Burlel 2 Cremetion 3 Rem	and from State	20b. PLACE	ANDDATE	OF DISPO	SITION (Na	me of		OATE 20c. LO	CATION —	City or Ton	wn, Stata		
	4 Donation 5 Other (Specify)	OVER FROM State	Lee F		al H	lome	Octo	ber	29,1995	Clin	ton,	Maryland		
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE	1000 111	21 IP-25-	22	. NAME AN	D ADDRESS	OF FACI	ILITY					
1 1	M. I Ch	-//_	M00668	}					eral Home,			M - 00	-	
\Box	23. PART I. Enter the divesses, or o	complications that	caused the de	auth Do r	not ente	r the mo	da of dylne	g, auch	mont Rd.,	Lna.	tan F.	Approximata	64	
	shock, of heert fellure, IMMEDIATE CAUSE (Fine)	List only one ceus	se on each line	D.							,	Interval Betwee		
	disease or condition	CERFI	RRIDIA	COL	1 4	R	ACC	110	IM			M	eun CC	
	resulting in death)	DUE TO	OR AS A CONSE	OUENCE OF	F):	,	// ()	IDF	W [TUNDTE	رج	
z		ARTERIO	SCLERI	TIC	CE	REBI	COVAC	Chil	ENT 4 ALSERS	E		YEAR!	5	
ERTIFICATION	If any, leeding to immediate	OUE TO (OR AS A CONSE	OUENCE OF	F):	1			1 126/12	P		11-111-		
\delta	cause. Enter UNDERLYING CAUSE (Disease or injury	c												
1 1	that initiated events	DUE TO (OR AS A CONSE	QUENCE OF	F):									
H	Tourishing in death) CAST	d												
ایدا	PART II. Other significent condition	a contributing to	deeth but not i	resulting i	In the u	nderlying	ceuse giv	ven in P	ert I. 24s. WAS AN	AUTOPSY	24b.	WERE AUTOPSY FINDIN	GS	
MEDICAL	D		ULMON									AMAILABLE PRIOR TO COMPLETION DF CAUSE	E	
	GASTRITIS . T.		WITE Y						1 YES 2	XMO		OF DEATH?		
	DID TOBACCO USE CONT							RTAIN	<u> </u>			1 TES 2 NO		
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?			CE OF OEAT			OTTOE	KIMIT					\dashv	
Sic	1 YES 2 NO	HOSPITAL:	ER/Outpatient 3	□ DOA	OTHE 4 Nu		5 🗆 Rosk	dence 8	☐ Other (Specify)					
Ě	27. MANNER OF DEATH	28a. OATE OF I (Month, Da		28b. TIM		28c. INJU	JRY AT		28d. DESCRIBE HOW IF	JURY OC	CUREO		\dashv	
ВУ	1 Netural 5 Pending 2 Accident Investigation	(MORIT, Da	y, roar)	ins	M	1 Y		NO						
	3 Suicide 8 Could not be	28s. PLACE OF building.	INJURY - At ho	ome, lerm, s	street, lac	tory, office)		281. LOCATION (Street a	nd Numbe	or Rural A	oute Number,	\neg	
	4 Homicide determined								City or Town, State)					
COMPLET	29a. CERTIFIER 1 CERTIFYING PHYSI	CIAN: To the beat of r	ny knowledge, da	ath occum	d at the	time, deta	and place, a	nd due to	o the cause(a) and man	ner as ate	ted.			
No.	one) 2 MEDICAL EXAMINE											and manner as stated		
Ŭ	296. SIGNATURE AND STILE OF CENTURE					T	29c. LICEN					(Month, Day, Year)	\dashv	
98	1050						NI	29	06	> /	2/2	2/97		
디오비	20. HAME AND ADDRESS OF BEINGON WILL	O COMPLETED CALLS	. 05 05 1711 1175				4)10	1.1	0 0	-	0/2	3/1		

WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

8926 Woodyard Road #602 Clintonm, MD 20735

32 PEGISTRAR'S SIGNATURED Julia D'AUGUST hardall



DIVISION OF VITAL RECORDS, P.O.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 1250 1995 nargares oone October 23 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (in yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State or Foreign HOURS 1 M 2 F 579-18-7184 YRS. March 5,1906 89 Virginia burial-transit permit, Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Wilson Health Care Center Gaithersburg Montgomery RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Maryland Montgomery Gaithersburg t X YES 2 □ NO FUNERAL 10s. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 301 Russell Avenue 20877 United States ours after death. Page 6 may be retained by the hospital or attending physician, 12, WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Maxican, Puerto Rican, etc.)
1 YES 2 NO Specify: 11. MARITAL STATUS RACE — American Indian, Black, White, atc. **MARYLAND 21215-0020** 1 Never Married 2 Married IF YES, GIVE WAR OR DATES BY 3 🔀 Widowed 4 🗌 Divorced detached for use as the White COMPLETED 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) Registered Nurse Nursing 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) e notified at Henry H. Rogers Ada Frances Cole BE page 5 should 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Charles Edward Boone 4408 Rendale Court, Olney, Maryland 20832 be METHOD OF DISPOSITION 20s. METHOD OF DISPOSITION
1 XBurial 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name pl cemetery, crematory or other place) October 26, 1995 Cate of Heaven Cemetery. 20c. LOCATION - City or Town, State Bethesda, Maryland must funeral director, 4 Donation 6 Other (Specify) Silver Spring, Maryland examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Mantgarery Cremat. 22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/Rockville, Inc., 300 W. Montgomery Ave Rockville, Maryland 20850-2805 M00348 the medicai 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, filled in by Approximate shock, or haert fellure. List only one ceusa on each line. 0 IMMEDIATE CAUSE (Final Onset and Death the diseese or condition erebral mo. nrom bosis completely reaulting in death) traumatic event. executed with DUE TO (OR AS A CONSEQUENCE OF): and com teriosclerosis erebral CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE prior to If any, leading to immediate cause. Enter UNDERLYING the attending physician Mental Hygiene prior to OR ATTENDING PHYSICIAN: The law requires that the death certificate be other t CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated eventa resulting in death) LAST PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS Health and any COMPLETION OF CAUSE t T YES 2 NO OF DEATH? Shows 2 1 Tes 2 YO been it. of has by Dept. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) certificate h **EXAMINER?** 1 YES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 6 Other (Specify) 0 27. MANNER OF DEATH 28e. DATE OF INJURY 28b. TIME O 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED this c marked. Natural Accident 1 YES 2 NO After t BY 28a. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 3 Sulcide 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State) 90 DIRECTOR: Hours after COMPLETED 8 Could not be 28 4 Homicide tem 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and menner as stated. FUNERAL within 72 h Ξ HOSPITAL TO THE HOSPITA
TO THE FUNERA
De filed within 7. 2 MEDICAL EXAMINER: On the ation, in my opinion, death occured at the time, data and place, end due to the cause(s) and manner as stated. 29c. LICENSE NUMBER 29d. DATE SIGNED (Month. Day, Year) BE mī ctober 23 HO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

31. DATE FILED (Month, Day, Year)

24 1995

32. REGISTRAR'S SIGNATURE

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	1 - STATE REGISTRAR	S	TATE OF N	MARYLA	ND / DEPAI CERTIF					NTAL HYGIEN REG. NO	_			
	1. DECEDENT'S NAME (First,		-									EAR	3. TIME OF DEATH	
	Miriam 4. SOCIAL SECURITY NUMBER	Russel			ehling yrs. last birthday)	IF UNDER	VEAD	IF UNDER 2		ctober 2			3:20 A. M	
	578-80-1859		M 2 🔀 F	87		MONTHS	DAYS	HOURS	88194	(Month, Day, Year)	1908	Country)		
	9a. FACILITY NAME (# not ins		nd number)			9b. CITY,	TOWN (OR LOCATION		1011 21,	1908 Wisconsin			
OR	Althea Wood		rsing H	Home		9	ilv	ver Spring Montgomery					aru	
딦	RESIDENCE OF DEC	10b. COUNTY		-	10c CI	Y, TOWN O				10d. INSID				
DIRECTOR	MD	Mont	gomery	7				er Sp	rina		LIMITS?			
	10e. STREET AND NUMBER		0 ,				_	. ZIP CODE	TIME	10g. CITIZEN OF WHAT COUNT				
FUNERAL	3701 Inter	nationa]	L Drive	e #	415	20906						SA		
Ę	11. MARITAL STATUS 1 Never Married 2 2 1		WAS DECEDENT FORCES? 1			13. V	AS DEC	ENDENT OF	RIGIN? (Specify Yearto Ricen, etc.)		. RACE -	- American Indian, White, etc.		
ΒY	3 Widowed 4 Divort	ES			2 1 NO	, , , , , , , , , , , , , , , , , , , ,		Specify						
											SINESS/INDUS	TRY		
LETED	(Specify only highest grade completed) [Give kind of work done during most of working life. Do NOT use retired.) [Give kind of work done during most of working life. Do NOT use retired.)									, and the second				
COMPL	4 Homemaker										Own H	ome		
-	17. FATHER'S NAME (First, Mic Frank H. Ri						First, Middle, Maiden	Sumame)						
B	19a. INFORMANT'S NAME (7/1	105 MAILING	ADDRESS	(Camera of		ide Ro	Number, City or Tow							
5													- MD 2000	
	20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of										CATION - City or Town, Stata			
	4 Donation 5 Other (Specify)	0	Nat	ery, crematory or distance in the interest of	ther plece) emori	a1	Park	1	0/27 Fal	ls Chi	irch	Virginia	
	21. SIGNATURE OF FUNERAL	SERVICE LICENSE	E	,		22. N	AME AN	D ADDRESS	OF FACILIT	Y Joseph	Gawler	's	Sons	
	5130 WI Ave. NW Washington, D.C. 20016												20016	
	23. PARTY. Enter the diseases, or compilections that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart fellure. List only one cause on each line. Approximate interval Between Constant Cause (Figs.)													
	IMMEDIATE CAUSE (Fine)												Onset and Death	
	resulting in death)												2 weeks	
_	DUE TO (OR AS A CONSEQUENCE OF): Parkinson's Disease											10 years		
0	Sequentially list conditions, If smy, leading to immediate Due to (or as a consequence of):										10 years			
S	cause. Enter UNDERLYIN CAUSE (Disease or injury													
CERTIFICATION	thet initieted events resulting in death) LAST		DUE TO	(OR AS A C	CONSEQUENCE O	F):								
		d												
CAL	PART ii. Other significen	t conditions cor	ntributing to	death but	not resulting	In the unc	leriying	g ceuse giv	ven in Part	i. 24s. WAS AN PERFOR			VERE AUTOPSY FINDINGS	
MEDIC										1 TYES 2	™ NO		OMPLETION OF CAUSE OF DEATH?	
Σ	DID TOBACCO US	E CONTRIBLI	TE TO CAL	LICE OF	DEATH VI	C 🗆 N	0 5	LINICE	RTAIN [,		1	YES 2 NO	
SICIAN:	25. WAS CASE REFERRED TO		TE TO CA		DEATH II			UNCE	KIAIN L	7				
Sic	EXAMINER? 1 YES 2 X NO		SPITAL: Inpatient 2 -	ER/Oulpat	lant 3 DOA	OTHER		a 5 🗆 Rasi	dence 6 🗆	Other (Specify)				
PH	27. MANNER OF DEATH		28a. DATE OF (Month, Da		28b. TIM		28c. INJ		_	DESCRIBE HOW I	NJURY OCCUR	ED		
ΒX	1 3 Natural 5 Page 10	ending vestigation				М	1 🗆 Y	rES 2 🗌	NO					
		ould not be	28a. PLACE Of building,	rtc. (Specif)	At home, farm,	street, facto	ry, office	•	281	LOCATION (Street I City or Town, State)		Rural Rou	ute Number,	
<u>.</u>	29a. CERTIFIER													
COMPL	(Check only									e cause(a) and mar			and manner as stated.	
- 1	29b. SIGNATURE AND TITLE C		/ _			, ,	1		SE NUMBER	oata and piace, an				
B	Vorunth	S. 1H	3 00	2					21900				Aonth, Day, Year)	
임	30. NAME AND ADDRESS OF													
	Smith S. Ho,				11 Ave.	#28	0	Takom	a Par	k, MD	20912			
	31. DATE FILED (Month; Day, Ye	ear)	32. REGISTRAI	R'S SIGNAT	URE									

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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	this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit mermit pages 1, 2, should be detached for use as the burial-transit mermit pages 1, 2, should be detached for use as the burial-transit mermit pages 1, 2, should be detached for use as the burial-transit mermit pages 1, 2, should be detached for use as the burial-transit mermit pages 1, 2, should be detached for use as the burial-transit mermit pages 1, 2, should be detached for use as the burial-transit mermit pages 1, 2, should be detached for use 3 the burial-transit mermit pages 1, 2, should be detached for use 3 the burial-transit mermit pages 1, 2, should be detached for use 3 the burial-transit mermit pages 1, 3, should be detached for use 3 the burial-transit mermit pages 1, 3, should be detached for use 3 the burial-transit mermit pages 1, 3, should be detached for use 3 the burial-transit mermit pages 1, 3, should be detached for use 3 the burial-transit mermit pages 1, 3, should be detached for use 3 the burial-transit mermit pages 1, 3, should be detached for use 3 the burial-transit mermit pages 1, 3, should be detached for use 3 the burial-transit mermit pages 1, 3, should be detached for use 3 the burial-transit mermit pages 1, 3, should be detached for use 3 the burial-transit mermit pages 1, 3, should be a should be detached for use 3 the burial-transit mermit pages 1, 3, should be detached for use 3 the burial-transit mermit pages 1, 3, should be detached for use 4 the burial-transit mermit pages 1, 3, should be detached for use 3 the burial-transit mermit pages 1, 3, should be detached for use 4 the burial-transit mermit pages 1, 3, should be detached for use 4 the burial-transit mermit pages 1, 3, should be detached for use 4 the burial-transit mermit pages 1, 3, should be detached for use 4 the burial-transit mermit pages 1, 3, should be detached for use 4 the burial-transit mermit pages 1, 3, should be detached for use 4 the b	i	
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YSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician	certifical	h the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	or He
S PHYS	er this c	th with	arkad
AL UH ALLENDING PHYS	RECTOR: After this	e filed within 72 hours after death with the	PORTANT If He marked or Hem 23 shows any injury or other traumatic event the medical avantage he notified at once
OH A	DIRECT	hours at	tam 2
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	FOR 1 STATE		STATE OF MA	ARYLAND A	/ DEPAR	TMENT O	F HEALTH	AND I	MENTAL HYGIEN	IE .		00010	
	REGISTRAR			C	ERTIF	CATE	OF DEAT	TH	REG. NO				
	1. DECEDENT'S NAME (First,	Middle, Last)	21					711	2. DATE OF DEATH	AY	W#45	3. TIME OF DEATH	
	James	S. Y.	Bake	25					October 1		99 C	1000 H	
	4. SOCIAL SECURITY NUMB	ER	5. SEX (. AGE (In yrs. le	ast birthday)	IF UNDER I Y			7. DATE OF BIRTN	8. BIRTHPLACE (State or Foreign			
	172-18-6991 90. FACILITY NAME (If not in-		1 M 2 F	79	YRS.		WN OR LOCATIO		Dec. 4,19	v -		nsylvania	
Œ	Shady Grove			(to 1	1				AIR		INTY OF E		
16	RESIDENCE OF DEC		ist nosp.	LLai		B	ockvil	Te		M	Montgomery		
🗒	10e. STATE	10b. COUNTY			10c. CITY	, TOWN OR L	OCATION					10d, INSIDE CITY	
DIRECTOR	Maryland 100. STREET AND NUMBER	Mon	tgomery			R	ockvil			14		LIMITS? 1 XYES 2 NO	
N N							10f. ZIP CODE			10g. CIT	IZEN OF	WHAT COUNTRY?	
Ü	126 South Ac	lams St	reet				2	0850		Uni	ted	States	
FUNERAL	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISP, FORCES? 1 YES 2 NO 17. YES 2 NO 18. WAS DECENDENT OF HISP, FORCES? 1 YES 2 NO 19. WAS DECENDENT OF HISP, FORCES? 1 YES 2 NO 19. WAS DECENDENT OF HISP, FORCES? 1 YES 2 NO 11. YES 2 XI NO Solet									s or No-	14. RAC	E — American Indian,	
BY	1 Never Married 2 🖎		IF YES, GIVE WAT	OR DATES	NO		YES 2 X NO				Spec	k, White, atc.	
	3 Widowed 4 Divo	ced									, , , ,	White	
ED		EDENT'S EDUCA		16a. Di	ECEDENT'S	USUAL OCCU	PATION g most of workin	_	16b. KIND OF BU	SINESS/IN	DUSTRY		
H	Elementary/Secondary (0-		College (1-4 or 5 +)	in	e. Do NOT use	retired.)	y most or wordn	v					
亘	12		Colored Laboratory	Let	tter (Carrie	r		US Post	al S	ervi	ce	
COMPL	17. FATNER'S NAME (First, Mi	ddle, Last)					18. MOTH	IER'S NA	ME (First, Middle, Malden		-		
	Charl	es O.	Baker						a B. Stewa				
BE	19e. INFORMANT'S NAME (7)		DOME	1	A 1840 MI	AD encire :							
2	Gordon C. Ba								loute Number, City or Tox				
1										lle,	Mary	land 20850	
	20e. METHOD OF DISPOSITION 1 X Buriel 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION // James of Campaign of Company Co											own, State	
	4 Donation 5 Other (Specify) Evergreen Memorial Cemetery Point Marion, PA											n, PA	
	21. SIGNATURE OF FUNERAL	SERVICE LICEN	ISEE			22. NAN	E AND ADDRES	S OF FAC	NUTY Robert	A. P	dami	rev Euneral	
	▶9/1		Vit	- 2000	2010	Hom	e/Rock	ville	e, Inc., 3	300 W	. Mo	ntgomery Ave	
	viacre	LL G	Mula)348	Koc	kville	, Ma:	ryland 20)850 -	2805		
	23. PART I. Enter the di- shock, or he	seases, or cor art failure. Lie	mplications that o	aused the de	eath. Do n	ot enter the	mode of dyl	ng, such	aa cardiac or resp	iratory ar	reat,	Approximata	
	IMMEDIATE CAUSE (Fin		,,		••							Onset and Death	
	disease or condition resulting in death)	• nu	100	111								4 1	
	resolding in death)		DUE TO (O	H AS A CONSE	OUENCE OF):						MAYE	
-		1410	0 1	1.4	1 0							4	
CERTIFICATION	Sequentially list condition		DUE TO (O	R AS A CONSE		5 6	2					Talayin	
A	If any, leading to immed cause. Enter UNDERLYII			1	77	,.							
[유	CAUSE (Disease or injui		DUE TO (O	R AS A CONSE	OHENCE OF								
Ē	that initiated events resulting in death) LAST		DOE 10 (O	N MS A COMSE	OUENCE OF):							
1 15 1		d.										,	
1 7 1	PART II. Other aignificer	nt conditions	contributing to de	eth but not	resulting is	the under	lying ceuse g	lves in t	Part I no. unn	ALITYCEAN		WEDE ALIENDAY WATER	
PHYSICIAN: MEDICAL	0.1.4	1 .	1.		. Journal II	. ure under	rying couse g	ו חוו ווסאו	Part I. 24a. WAS AN PERFOI		246	AVAILABLE PRIOR TO	
ă	Uchylia	UTI	7 / 0	TVO	(6				1 🗀 YES 2	NO		COMPLETION OF CAUSE OF CEATH?	
불	Azótco	nig	10	em t	nti	6				/ -		1 TYES 2 NO	
Ξ	DID TOBACCO US	SE CONTRI	BUTE TO CAU	SE OF DEA	TH YES	S NO	☐ UNC	ERTAIN	i Da				
💆	25. WAS CASE REFERRED TO	MEDICAL		26. PLA	CE OF DEATH	H (Check only	one)						
1 25	EXAMINER?		OSPITAL:			OTHER:							
=	27. MANNER OF DEATH		280. DATE OF IN		28b. TIME			Hdence (8 Other (Specify)	ai se para	Date:		
1 1	~	Pending	(Month, Day,		INJU	PRY	WORK?		28d. DESCRIBE NOW I	NJURY OC	CURED		
B		nvestigation					YES 2	NO					
		Could not be	28e. PLACE OF I building, ate	NJURY — At ho :. (Specify)	ome, ferm, st	reet, factory,	office		28f. LOCATION (Street City or Town, Stete)	and Number	r or Rural F	Route Number,	
	4 Nomicide d	etermined							,,,				
ايرا	29a. CERTIFIER 1 CERTI	FYING PNYSICIA	N: To the best of m	knowledge de	eath occurre	d at the time	data and plan-	and don	to the cause(e) and mar	1004 04 -4			
1 100 1												e) end manner se stated.	
Σ					veatigetion	, п. ту орин	, westi occun	rur art (file 1	mos, use and place, er	ru que to ti	ne ceuse(e	y wha manner se stated.	
COMPLETED							29c LICE	NSE NUM	BER	29d. DAT	E SIGNED		
	29b. SIGNATURE AND TITLE						200. 2102			0.000	_ 0101120	(Month, Day, Year)	
BE			non				03	183	9 01	10	1 + 0	(Month, Day, Year) 6 - 19 19 11	
	296. SIGNATURE AND TITLE	OF CERTIFIER	A OMO	OF DEATH (ITE	M 27) (Type,	Print)	03	183	mont	10	1+0	The second secon	
BE	296. SIGNATURE AND TITLE	OF CERTIFIER	COMPLETEO CAUSE	OF DEATH (ITE	M 27) (Type, 1	Print) L	15 W	183	mont	10 m	10	The second secon	
BE	296. SIGNATURE AND TITLE	OF CERTIFIER	COun	SIGNATURE	1, m	Print) L	03	183	mont, mos	10	1+0	The second secon	
BE	296. SIGNATURE AND TITLE 30. NAME AND ADDRESS OF	OF CERTIFIER	COun	ford	1, m	Print) L	03 15 W	183	mont, mos	10	1+0	The second secon	

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within cours after death. Page 6 may be retained by the hospital or attending physic	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial page 15 should be detached for use as the burial.	traumatic event, the medical examiner must be notified at once.
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s that the death certif	ned by the attending phy	amy injury, or other
requires that the death certif	been signed by the attending phy	shows any injury, or other
: The law requires that the death certif	ate has been signed by the attending phy	tem 23 shows any injury, or other
YSICIAN: The law requires that the death certifi	s certificate has been signed by the attending phy	id, or item 23 shows any injury, or other
JING PHYSICIAN: The law requires that the death certif	After this certificate has been signed by the attending phy	marked, or Nem 23 shows any injury, or other
ATTENDING PHYSICIAN: The law requires that the death certifi	ECTOR: After this certificate has been signed by the attending physical phy	n 28 is marked, or item 23 shows any injury, or other
ITAL DR ATTENDING PHYSICIAN: The law requires that the death certifi	PAAL DIRECTOR: After this certificate has been signed by the attending phy	If Item 28 is marked, or Item 23 shows any Injury, or other
E HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certiff	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the formal property of the standard property of the standard physician and completely filled in by the standard physician and completely fille	be med within 72 hours are local with the State Cept. Or receit and mental higher prior to being. The medical examiner must be notified at once, IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once,

CLARENCE		TTON			2. DATE OF DEATH MONTH	4,1995	S. TIME OF DEATH				
4. SOCIAL SECURITY NUMBER 213-44-6733	5. SEX 6. AGE (THE DAYS	HOURS MIN.	7. DATE OF BIRTH (Month, Day, Vear) Mar. 9,	1946	BIRTNPLACE (State or Foreign Country) Maryland				
Shady Grove Acresidence of Decement				kville	EATN	MON'	OF DEATH TGOMERY				
10a. STATE 10b. COU	ntgomery	1	wn on Location				10d. INSIDE CITY LIMITS? 1 YES 2 NO				
23 N. Summit A	Ave., #102		101.	2087	J.S.A.						
11. MARITAL STATUS 1 Never Merried 22 Married 3 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2 X NO	If yes, spec		NIC ORIGIN? (Specify an, Puerto Rican, atc.) ly:	Yes or No- 14	RACE — American Indian, Black, White, atc. SpecifyWhite				
15. DECEDENT'S E (Specify only highest gri Elementary/Secondary (0-12)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use reliefed.) Landscape 16b. KIND OF BUSINESS/INDUS Lawn Serv									
17. FATHER'S NAME (First, Middle, Last) Louis A. Brit	tton	16. MOTHER'S NAME (First, Middle, Maide									
19e. INFORMANT'S NAME (Type/Print) Louella M. Britton (wife) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 800 Beard Hill Rd., Aberdeen, MD 21001											
23. PART I. Enter the diseases, of short, of Meart failur IMMEDIATE CAUSE (Final disease or condition resulting in death)	aDUE TO (DR.AS A	I the death. Do not a ach lina.		VILLE,			Approximate Interval Batwe Onset and De Down				
Sequantially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST B. UCOLULE DUE TO (DR AS A CONSEDUENCE OF): C. DUE TO (OR AS A CONSEDUENCE OF): d											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 140											
25. WAS CASE REFERRED TO MEDICAL 26. PLACE DF DEATH (Check only one)											
EXAMINER?	HOSPITAL: 1 Dinpatient 2 ER/Outp		HER: Nursing Nome 28c. INJU		6 Other (Specify)						
EXAMINER?		ORL THE OF			28d. DESCHIBE HO	W INJURY OCCUP	IED				
EXAMINER? 1 YES 2 NO 27. MANNER OF DEATN 1 Netural 5 Pending	26a. DATE DF INJURY (Month, Day, Year)	28b. TIME OF INJURY	WOR	K? S 2 NO							
EXAMINER? 1 VES 2 NO 27. MANNER OF DEATN	28a. DATE DF INJURY (Month, Day, Year) 28a. PLACE OF INJURY building. atc. /Soec	— At home, farm, street	M 1 YE		281. LOCATION (Stree City or Town, Ste		Rural Route Number,				
EXAMINER? 1 YES 2 NO 27. MANNER OF DEATN 1 Netural 5 Pending Investigation 3 Suicide 6 Could not 8 determined 29e. CERTIFIER (Check only 1 CERTIFYING PN	28a. DATE DF INJURY (Month, Day, Year) 28a. PLACE OF INJURY building. atc. /Soec	At home, farm, street	M 1 YE	S 2 NO	City or Town, Ste	nenner se stated.					

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spiral or attending physician. ned for use as the burial-transit permit. Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certifican be encoded withings hours after death. Page 6 may be retained by the hor	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detach be filed within 72 hours after obsert with the State Decr. of Health and Mental Hopiere prior to burist, communic. or removal.	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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1 - STATE REGISTRAR		STATE OF N	MARYLAND / CE	DEPART	CATE	OF H	EALTH DEAT	AND I	MENTAL HYGIENI REG. NO.	E		
1. DECEDENT'S NAME (FIRST,	Middle, Lest)	CRE	SPOR	7	6-	300	WI	0	2. DATE OF DEATH MONTH DA		YEAR 995	3. TIME OF DEATH
4. SOCIAL SECURITY NUMBER 577 10 7421		5. SEX 1 2 M 2 F	6. AGE (In yrs. last		IF UNDER		IF UNDER		7. DATE OF BIRTH (Month, Day, Year) Nov. 28,19		Count	HPLACE (State or Foreity)
9a. FACILITY NAME (If not ins	titution, give st	reet and number)									INTY OF D	
Washington		entist Ho	spital		Takoma Park Mor						ontgo	omery
RESIDENCE OF DECI												
10e. STATE	10b. COUNTY			10c. CITY,	ITY, TOWN OR LOCATION							10d. INSIDE CITY
Maryland	Mon	tgomery		T	Takoma Park							LIMITS?
10e. STREET AND NUMBER						101	ZIP CODE	E		10g. CIT	IZEN OF	WHAT COUNTRY?
7051 Carroll Ave.,#315					20912					United States		
11. MARITAL STATUS 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES					H	yes, spe	ENDENT O	OF HISPAN on, Maxica Specify	HC ORIGIN? (Specify Yes n, Puerto Rican, etc.) //	or No—	14. RACI Black Spec	E - American Indian, k, White, etc.

9:05-AH (State or Foreign S.C. BY FUNERAL DIRECTOR y ISIDE CITY ES 2 NO DUNTRY? tates erican Indian, Black WW2 COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Sdary (0-12) College (1-4 or 5 +) Motor Vehicle Operator U.S. Government 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Theodore B. Brown BE Louise Moten 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Alex Brown 7051 Carroll Ave., #705, Takoma Park, MD. 20912 20a. METHOD OF DISPOSITION
1 ☑ Burial 2 ☐ Cremation 3 ☐ Rem 20c. LOCATION — City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE Mt. Olivet Cemetery 4 Donatton 5 D Other (Specify) 10/25/95 Washington, D.C. 22. NAME AND ADDRESS OF FACILITY
McGuire Funeral Service Inc. 7400 Georgia Ave., N.W., Wash., D.C. diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death IMMEDIATE CAUSE (Final disease or bondition resulting in death) BY PHYSICIAN: MEDICAL CERTIFICATION Sequentially list conditions if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO JOR AS A CONSEQUENCE OF that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 34b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE 24s. WAS AN AUTOPSY PERPORMED? 1 TYES 2 NO OF DEATHY 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN [25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH /Check only one. 1 TES 2 NO Inpatient 2 - ER/Outpatient 3 - DOA Home S ☐ Residence S ☐ Other (Specify) 27, MANISER OF DEATH DATE OF INJURY 28b. TIME OF BAJURY 20c. INJURY AT WORK? 384. DESCRIBE HOW INJURY OCCURED Natural Accident 1 YES 2 NO PLACE OF INJURY — At home, farm, street, factory, office building, str. (Topo/fr) 3 Dutchie COMPLETED 281. LOCATION (Street and Number or Hural Plaute Humber, Olly or Town, State) 6 Could not be 4 | Homiside CERTIFYING PHYSICIAN: To death occurred at the time, date and place, and due to the cause(a) and manner as atated. (Check only one) 2 MEDICAL EXAMINER stigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER BE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) Dottaber 22,1995 1 19895 2

1000	10010	· VUCOUTLANI
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MOBARAK KARIM, 76 10 CARROLL	ALE, STEZ40, TAKOM	APARK, MD

32. REGISTRAR'S SIGNATURE 24 1995

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hos	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: Il Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	FOR 1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPAR					MENTAL	HYGIEN REG. NO			
	t. DECEDENT'S NAME (First, Middle, Last)							2. DATE C				3. TIME OF OEATH
	Robert Ivan	Bell						Octob	er 25	, 19	95	11:00 A M
	4. SOCIAL SECURITY NUMBER	5. SEX 8. AGE	(In yrs. lest birthday)	IF UNDER		IF UNDER		7. DATE O	F BIRTH Day, Year)		8. BIRTH Count	IPLACE (State or Foreign
	075-05 - 5722	1 🔀 M 2 🗌 F	79 YRS.	MONTHS	DAYS	HOURS	MIN.	Aug.	22, 1	916		York
_	9e. FACILITY NAME (If not institution, give st	and the same of		9b. CITY	, TOWN (OR LOCATION	ON OF D	EATH		9c. COU	NTY OF D	EATH
DIRECTOR	1104 Cresthaven D	rive		Si	lveı	Spr	ing			Mo	ntgo	omery
E I	10a. STATE 10b. COUNTY		10c. CIT	Y, TOWN C	R LOCAT	ION						10d. INSIDE CITY
- I	Maryland Montg	omery	Sil	ver	Spri	ing						LIMITS? 1 YES 2 NO
AL	10e. STREET AND NUMBER				101	ZIP COO				t0g. CIT	ZEN OF	WHAT COUNTRY?
FUNERAL	1104 Cresthaven D					2090					USA	
3	1t. MARITAL STATUS t ☐ Never Married 2 ☒ Merried	t2. WAS DECEDENT EVER I	IN U.S. ARMED					NIC ORIGIN?		s or No-	14. RACI Blac	E — Americen Indien, k, White, etc.
BY	3 Widowed 4 Divorced	IF YES, GIVE WAR OR C			YES	2 NO	Speci	My.			Spec	hite
	15. DECEDENT'S EOUC	CATION	16a. DECEDENT'S	USUAL O	CCUPATIO	ON .		16b.	KIND OF BU	SINESS/IN		
COMPLETED	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind of life. Do NOT u	work done (se retired.)	during mo	st of workir	ng	-				1,767
MP	12	2	Ana1	yst					U.S.	Gove	rnme	ent
S	17. FATHER'S NAME (First, Middle, Lest)					18. MOTI	HER'S N	AME (First, M	iddle, Meiden	Sumame)		
BE	Robert H. Bell							nckle	4-			
2	196. INFORMANT'S NAME (Type/Print) Jean Bell							Route Numbe				ryland 20903
	20e. METHOD OF DISPOSITION	20	b.PLACE AND DATE				TVE	DATE	_	CATION -		
	1 Buriel 2 & Cremetion 3 Remo		metery.crematory or cort Linco				7	1				Maryland
	21. SIGNATURE OF FUNERAL SERVICE LIC		ore brite.	22.	NAME A	O ADDRE	SS OF F	ACILIT H1T	nes-Ri	inald		neral Home
	1	2 14	10 00	1	1800	New	Har	mpshir	e Ave	enue		
	23. PART I. Unter the diseases, or o	complications that cause	d the death. Do	not enter	11Ve	r Sp	ring	g, Man	yland	1 20	904	Approximate
	phock, or heart fellure.	List only one ceuse on	eech line.						ac or roup			interval Between Onset and Death
	iMMEDIATE CAUSE (Fine) disease or condition	PEDPM	FAI F	41/ 11	DE	•						2 7410
	reaulting in death)	DUE TO (OR AS	A CONSEQUENCE C	/1 6 V	حال							ZUID
Z		b. COMA-										2DHVS
CERTIFICATION			A CONSEQUENCE O			N 1-	114	A				204110
5	CAUSE (Disease or Injury	C. ARESUMED DUE TO (OR AS	A CONSEQUENCE C	11110	N/	400	UIV	INOVI	4			SPTYS
Ē	that initiated events resulting in death) LAST	REWRIEDA	IT HOAT	Ans	1	IN	0	ANICI	500			URC
S												1,2
AL	PART II. Other significant condition					g cause i	given in	Part I.	24s. WAS AN PERFO	DALEDO	248	MAILABLE PRIOR TO
ă	CHRONIC OBSTIGU	CIVE PUCINI	WHICH DIS	र्टा अ	_				1 YES	NO		OF DEATH?
M	DID TOBACCO USE CONTE	DIBLITE TO CALISE (DE DEATH V	ES 🔼	NO F	1 11546	ERTAI					1 YES 2 NO
PHYSICIAN: MEDICAL	25. WAS CASE REFERRED TO MEDICAL	CIBUTE TO CAUSE C	26. PLACE OF DEA			1 0146	EKIAI					
SICI	EXAMINER?	HOSPITAL:	Instinct 3 DOA	OTHE		a 6 🗆 B	a de de con	6 Other	(Specific)			
H	27. MANNER OF DEATH	28e. DATE OF INJURY	28b. Til	AE OF	28c. IN.	URY AT	saidence		CRIBE HOW	INJURY OC	CURED	
ВУ Р	1 Natural 5 Pending	(Month, Day, Year)	IN	JURY M		YES 2	NO					
ED B	3 Suicide 6 Could not be	28e. PLACE OF INJUR building, atc. (Spe	Y — At home, ferm,	etrent, fect	tory, offic	•			TION (Street Town, State		or Rural	Route Number,
ETE	4 Homicide determined	1110000						32, 3	nown, orang			
COMPLET		CIAN: To the bast of my know	wledge, death occur	red at the t	lme, date	end place	, end du	e to the caus	e(e) end ma	nner ee sta	nted.	
OM	one) 2 MEDICAL EXAMINE	R: On the basis of examination	on end/or investigati	on, in my o	opinion, c	leath occu	red at the	e time, date	end place, e	nd due to t	he ceuse(e) and manner ee stated.
ш	296. SIGNATURE AND TITLE OF CERTIFIER	1.				29c. LIC				29d. DA1	E SIGNE	(Month, Day, Year)
TO B	Hein (ifell	1-MD						52		► O	पा, ३	15,1995
	30. NAME AND ADDRESS OF PERSON WHO	HA, MD, 11:	SOI GED	RG1	4-1	VE	#-5	15. N	HONTE	NI	102	20902
	31. DATE FILED (Month, Day, Year) OCT 2 7 1995	Talin diwater h	artell.									
	0016/1995	mile as successive and										

TO BE COMPLETED BY FUNERAL DIRECTOR

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within as hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

STATE OF MARYLAND	/ DEPARTMENT	OF HEALTH	AND	MENTAL	HYGIENE
C	ERTIFICATE	OF DEAT	H		REG. NO.

FOR STATE REGISTRAR		STATE OF MAR			MENT OF H		MENTAL	HYGIENE REG. NO.		
1. DECEDENT'S NAME (First	t, Middle, Last)						2. DATE O			3. TIME OF DEATH
	C	larice R.	Brown				Octob	er 25,	1995	6:30 A M
4. SOCIAL SECURITY NUM	BER	5. SEX 6. A	GE (In yrs. lest t		UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE O		G. BIR	THPLACE (State or Foreign intry)
082-18-4508		1 M 2 X F	70	YRS.	ONTHS DAYS	R LOCATION OF D	Jan.	5, 1925		w York
5480 Wisco	nsin Av				Chevy		CAIN	n n	Montg	
RESIDENCE OF DE	10b. COUNTY		T	10c CITY 1	OWN OR LOCAT	ION				10d, INSIDE CITY
Maryland		gomery			y Chas					1 X YES 2 NO
100. STREET AND NUMBER					101	. ZIP CODE		10	g. CITIZEN O	F WHAT COUNTRY?
5480 Wisco	nsin Av	enue #605				20815			Unite	d States
11. MARITAL STATUS 1 Never Married 2 2 3 Widowed 4 Div	Married	12. WAS DECEDENT EV FORCES? 1 1	YES 2 NO		If yee, sp	ENDENT OF HISPA acity Cuban, Maxic 2 X NO Speci	en, Puerto Ri		Bi	ACE — American Indian, ack, White, etc.
15. DEC	CEDENT'S EDUCA	TION ompleted)	(Give	kind of worl	UAL OCCUPATION done during mo	ON st of working	18b.	KIND OF BUSINE	SS/INDUSTRY	
Elementary/Secondary (0-12)	College (1-4 or 5 +)		o NOT use n Sales	ectou.j			Real Es	state	
17. FATNER'S NAME (First, A	dicidle (ast)	4		Jares		18. MOTNER'S NA	AME /Floor AA			
Paul Stei							na Ber			
19a, INFORMANT'S NAME (- 0		19h.	MAILING AF	DRESS (Street :	nd Number or Rural		0	tete, Zip Codel	
Martin Bro						Gate Ro				land 20854
200 METHOD OF DISPOSE	MON		20h DI ACE AN	ID DATE OF	DISPOSITION /A/	me of	DATE		ION — City or	
1 X Burial 2 Cremati 4 Donation 5 Cthe	on 3 Ramov r (Specify)	al trom State	Beth M	atory or other	Cemete	ry ^O C\$95 ²	7,			New York
21 GIGNATURE OF FUNER	AL SERVICE LICE	Delu	, MO	00846	Chevy	Chase,	Luc . 1	Funera 7557 W: 20814	racons	e/Bethesda- in Avenue
IMMEDIATE CAUSE (Fi disease or condition resulting in death)	→ a.	Non-sma	11 Cel		g Cance	er				
Sequentially list condi if any, leading to immi cause. Enter UNDERLY CAUSE (Disease or in	ediate ring		AS A CONSEOU	,						
that initiated events resulting in death) LAS		DUE TO (OR	AS A CONSECU	JENCE OF):						
PART II. Other eignific							Pert I.	24a. WAS AN AUT PERFORME 1 YES 2 X	0?	24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 X NO
DID TOBACCO I		BUTE TO CAUS				UNCERTA	N 🗆			
25. WAS CASE REFERRED EXAMINER? 1 X YES 2 NO		HOSPITAL:		- 0	(Check only one) THER: Nursing Hor	ne 5 V i Residence	6 Other	(Specify)		
27. MANNER OF DEATN	Pending Investigation	28a. DATE OF INJI (Month, Day, Y	URY	28b. TIME (OF 28c. IN.	URY AT PRICE	_	CRIBE NOW INJU	RY OCCURED	
0 0 0 1-10-	Could not be determined	28s. PLACE OF IN building, atc.	JURY — At horr (Specify)	ia, tarm, atri	el, factory, offic			TION (Street and ir Town, State)	Number or Rur	ral Route Number,
[Griden brity 12		IAN: To the best of my								se(a) and manner as stated.
29b. SIGNATURE AND TITL	Most	COMPLETEO CAUSE O	OF DEATH (ITEM	27) (Type, P	rint)	20c. LICENSE NO. 2054		1. (,)	1	AED (Month, Day, Year) 26/95
Joseph P.	Catlett	, M.D., 1	10 Irv			N.W., W	ashing	gton, D	.C. 2	0010-2975
31. OATE FILEO (Month, Day OCT 2 7 19		de de de de de de de de de de de de de d	ardall							

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
MPORTANT: if item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND	MENTAL HYGIENE
CERTIFICATE OF DEATH	REG. NO.

	FOR 1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPARTI			MENTAL HYGIENI REG. NO.	E		
	1. DECEDENT'S NAME (First, Middle, Last)	7 B	1	3802	OST	2. DATE OF DEATH	"231 4	3. TIME OF DEATH	
	4. SOCIAL SECURITY NUMBER 091-10-3490	1X M 2 🗆 F 🛛 8	35 YRS. M	F UNDER 1 YEAR ONTHS DAYS		7. DATE OF BIRTH (Month, Day, Year) NOV. 22, 1	.909 F	BIRTHPLACE (State or Foreign Country) Oland	
ביוטו	Suburban Hospital Residence of decedent		8	Bethes	da	ATH	Mont	gomery	
Sing	10a. STATE 10b. COUNT None None			town on Locat			10d. INSIDE CITY LIMITS? 1 X YES 2 NO		
TWU	100. STREET AND NUMBER 5400 Connecticut				ZIP CODE 20015		10g. CITIZEN OF WHAT COUNTRY? United States		
מו במו	11. MARITAL STATUS 1 Never Married 2 Married 3 XX Widowed 4 Divorced	12. WAS DECEDENT EVER IF FORCES? 1 YES, GIVE WAR OR D	2 X NO	If yea, spe	ENDENT OF HISPANI ocity Cuben, Mexican 2 X NO Specify:	IC ORIGIN? (Specify Yea i, Puerto Rican, etc.)		RACE — American Indian, Black, Whita, etc. Specify: White	
FIED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	CATION s completed) College (1-4 or 5+)	ille. Do NOT use i	rk done during mo: retired.)	N st of working	16b. KINO OF BUS			
TIMOS	17. FATHER'S NAME (First, Middle, Last)	5+	Chiropra	ctor		Health AE (First, Middle, Meiden			
20 01	Oscar Brozost 190. INFORMANT'S NAME (Type/Print) Jay Brozost				nd Number or Rural R	Bernstein oute Number, City or Town Washing			
	20a. METHOD OF DISPOSITION 1X Burial 2 Cremation 3 Ram 4 Donation 5 Other (Specify)	noval from State 20	b. PLACE AND DATE OF metery, crematory or othe Vellwood C	DISPOSITION (Na	me of	DATE 20c. LO	CATION — City	or Town, Stata New York	
	21. SIGNATURE OF FUNERAL SERVICE LI		PP	Rapp F	uneral S	ervices, P	. A.		
Miricalion	shock, or heart feliure. List only one ceuse on each line. IMMEDIATE CAUSE (Final							Approximata interval Between Onset and Death Inschole I day 3455	
. MEDICAL OF	PART II. Other aignificent conditions contributing to death but not resulting in the underlying cause given in Part I. 24e. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO						24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 X NO		
SICIAIN	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 — YES 2 NO	HOSPITAL:	28. PLACE OF DEATH	(Check only one)	e 5 🗆 Rasidence				
or rn i	27. MANNER OF DEATH 1 V Naturel 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME	OF 28c. INJ		28d. DESCRIBE HOW II	NJURY OCCUR	ED	
2 Accident 3 Suicida 8 Could not be detarmined 25a. PLACE OF INJURY — At home, farm, streat, factory, office building, atc. (Specify) 25a. PLACE OF INJURY — At home, farm, streat, factory, office City or Town, State) 25b. LOCATION (Street and Number or Rurel Route City or Town, State)							Rurel Route Number,		
Cimic	anal stay	BICIAN: To the best of my known ER: On the basis of examination						ause(a) and manner as stated.	
O DE	29b. SIGNATURE AND TITLE OF CERTIFIE Med Alexander	n MS			29c. LICENSE NUM DIA	572	29d. DATE S	IGNED (Month, Day, Year) 0-23-95	
	30. NAME AND ADDRESS OF PERSON WI Neil A. Corre	10 COMPLETED CAUSE OF D	BATURE -	sin Av	e #800	Chevy C.	bese,	191 20815	
	31. DATE FILED (Month, Day, Year) OCT 2 7 1995	32. REGISTAR'S SU	ardall						

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

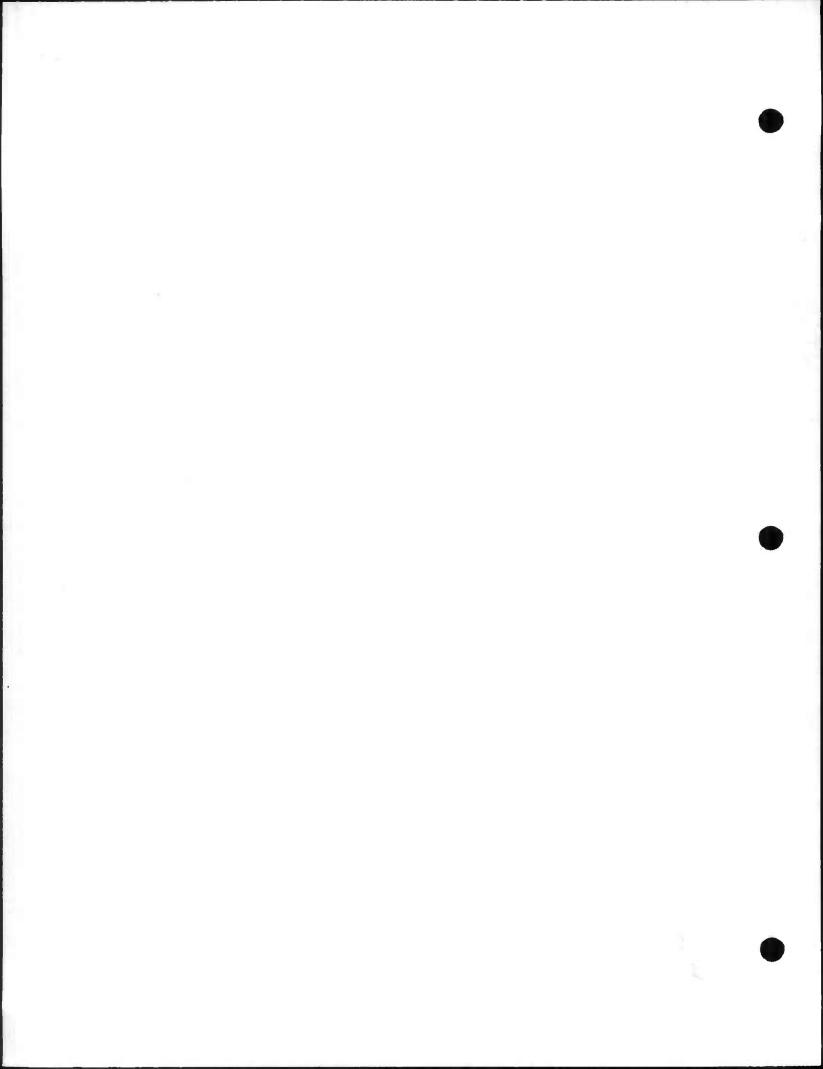
TO THE HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be find within 72 hours after health with the State Dent of Health and Mental Honiene prior to burial, cremation, or removal.	is marked
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	FOR 1 - STATE REGISTRAR	STATE OF MARYLAN		MENT OF H		MENTAL HYGIE REG. N				
	1. OECEOENT'S NAME (First, Middle, Last) FRAN		OKE			2. DATE OF DEATH MONTH	DAY 25	YEAR 95	TIME OF OEATH	
	4. SOCIAL SECURITY NUMBER 219-22-4151 9a. FACILITY NAME (If not institution, give str	1½ M 2 □ F 6	6 YRS.	MONTHS DAYS	HOURS MIN.		1929	929 Maryland 9. SIRTHPLACE (State or Foreign Country) 929 Maryland		
DIRECTOR	Northwest Hosp:	ital Center			llstown			timo		
	Maryland Cari	roll		stmins				,	Od. INSIDE CITY LIMITS? YES 2 NO	
FUNERAL	52 Goni Terrace				21157				States	
ВХ	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U FORCES? 1 TYES IF YES, GIVE WAR OR DATE	2 XNO	If yes, spe		IIC ORIGIN? (Specify n, Puerto Rican, etc.)	fee or No		- American Indian, White, atc. White	
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT use	ork done during mos retired.)	n st of working oke & S	16b. KIND OF E			ntractor	
BE COM	17. FATHER'S NAME (First, Middle, Last) Robert J. Cooks		wiist t	.п. со		ME (First, Middle, Maid		ty_Co	ontractor	
TO B	19a. INFORMANT'S NAME (Type/Print) Kathleen Cooke					ad, Wes			MD 21157	
	20a. METNOD OF DISPOSITION 1 X Burlal 2 Cremation 3 Ramo 4 Donation 5 Other (Specify)	Me Me	LACE AND DATE OF OTHER BOOK B	ranch (7º1/0/28/ Cemeter	Y W	location — estmi		er, MD	
	21. SIONATURE OF FUNERAL SERVICE LICE ** **Katherine**	Pritts - Swel	tur	Pri		eral Ho			el .nster, MD	
NOI	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF):								interval Between	
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST d.									
PHYSICIAN: MEDICAL C	PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY PERFORMED? t □ YES 2 NO							WAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
NAI:	DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26.	PLACE OF DEATH	d (Check only one)	UNCERTAIL	1X				
1YSIC	1 VES 2 NO	HOSPITAL: 1 Inpetient 2 ER/Outpeti				8 Other (Specify) 28d. DESCRIBE HOT	u an alamy oo	Ounen.		
BY PI	t Natural 5 Pending 2 Coldent Investigation	(Month, Day, Year)	INJU	M 1 1	RK7 'ES 2 NO	200. DESCRIBE NO	V INJURY OC	CORED		
0	3 Suicide 8 Could not be detarmined 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28a. PLACE OF INJURY — At home, farm, street, factory, office City or Town, State) 28b. LOCATION (Street and Number or Rural Route Number, City or Town, State)								ute Number,	
COMPLET	institution of the contract of	CIAN: To the best of my knowled R: On the basis of examination a							and manner as stated.	
TO BE C	29b. SIGNATURE AND TITLE OF CERTIFIER	mo			29c. LICENSE NUMBER 3750			29d. DATE SIGNED (Month, Day, Year) DOCTOBER 2594		
	30. NAME AND ADDRESS OF PERSON WHO	ET NOOF	THW	Print) EST	HOSPI	TAL	ENT	ER		
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATION	117							

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	500											9	5	33620
	1 - STATE REGISTRAR		STATE OF N	IARYLA					DEATH AND	MENTA	REG. NO			
	1. DECEDENT'S NAME (First CHARLES I.	CALLC	WAY, SR.				CA	1)	oway	2. DATE	OF DEATH		YEAR 995	3. TIME OF DEATH P
	4. SOCIAL SECURITY NUMI 218-16-648	32	5. SEX 1 [XM 2] F	6. AGE (In	n yrs. lasi	t birthday) YRS.	MONTHS D	EAR AYB	IF UNDER 24 HRS. HOURS MIN.	(Mont	OF BIRTH	1925	a. BIRTI Count Md	
POR	9e. FACILITY NAME (If not in PENINSULA	REGION		L CE	NTE	R			BURY	EATH			ICOM	
DIRECTOR	RESIDENCE OF DEC	10b. COUNTY	,			10c. CIT	Y, TOWN OR	LOÇAT	TION					10d. INSIDE CITY
	De .	Suss	ex				Delmar							LIMITS7
RAI	815 E. Gro							101	1. ZIP CODE 19940				SA	WHAT COUNTRY?
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 X 3 Wildowed 4 Divo	Married	12. WAS DECEDENT FORCES? 1 IF YES, GIVE W WW II	EVER IN AR OR DAT	U.S. ARI 2 N TES	MED	If y	s, sp	ENDENT OF HISPA ecity Cuban, Mexico 2 NO Specia	an, Puerto I	17 (Specify Yes Rican, etc.)			E — American Indian, k, White, etc.
TED	15. DEC (Specify onl)	EDENT'S EDUC y highest grade	CATION completed)		16a. DE(CEDENT'S	USUAL OCCU work done duri se retired.)	JPATIC ng mo	ON est of working	16b	KIND OF BU	SINESS/IN	DUSTRY	
COMPLET	Elementary/Secondary (I	2	College (1-4 or 5+				se retired.) f Way			D	elmarv	a Po	wer (Co.
O.	17. FATHER'S NAME (First, M							0	18. MOTHER'S NA					
BE (William I.		way		_				Martha					
2	Jessie M.	,,	av						St. Del				p Code)	
	20s. METHOD OF DISPOSIT 1 Burlel 2 Crematic 4 Donation 5 Other	ION on 3 🗆 Reme			PLACEA	NDDATE	OF DISPOSITION	ON (Na		DAT	20c. LO	CATION -	City or To	
	21. SIGNATURE OF FUNERA		ENSEE 1/7	1 3	L. 1	сер	22. NA	ME AN	D ADDRESS OF FA	CILITY			ar, I	Je.
	willia	w M	Mon				13	E.	Funeral Grove S	t. De	lmar.	De.	1994	40
ATION	23. PART I. Enter the d shock, or h IMMEDIATE CAUSE (Fir disease or condition resulting in death) Sequentially list condit if any, leading to immeasus. Enter UNDERLY!	lons,	DUE TO	OR AS A	CONSEC	UENCE O	Asc	75	hole which all					Approximate interval Between Onset and Death Run Kunter
CERTIFICATION	CAUSE (Disease or inju that initiated events resulting in death) LAS	iry 1	DUE TO	OR AS A	CONSEO	UENCE O	F):							
MEDICAL (PART II. Other significe	ent condition	s contributing to	deeth bu	t not re	aulting	in the unde	rlying	cause given in	Part I.	24e. WAS AN PERFOR	MED?	24b.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
ME	DID TOBACCO U	SE CONTE	DIRLITE TO CAL	ISE OF	DEAT	ru ve	C \square NC		LINICEDTAL					1 YES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO EXAMINER?						TH (Check only		UNCERTAI					
YSIC	1 TYES 2 THO		HOSPITAL:	ER/Outpat	tient 3	□ DOA	OTHER: 4 - Nursing	Home	e 5 🗆 Residence	8 🗆 Other	(Specify)			
ву Рн		Pending Investigation	28s. DATE OF (Month, Da	y, Year)			M 1	WO!	ES 2 NO	28d. DES	CRIBE HOW II	NJURY OC	CURED	
ETED		Could not be datarmined	28s. PLACE Of building, i	INJURY - itc. (Specif)	— At hon	ne, term, i	street, factory,	office		281, LOC	ATION (Street a or Town, State)	nd Number	or Rural F	Route Number,
COMPLE			CIAN: To the best of ex) and manner as attated.
BE	29b. SHOWATURE AND TIPLE	OF CERTUPIER	25						29c. LICENSE NUI	MBER 3		29d. DAT	E SIGNED	(Month, Day, Year)
2	30. NAME AND ADDRESS OF	PERSON WHO	E + he	e of DEAT	TH (ITEM	27) (Typo,	Print)	7	Rud	SAL	isau	ry,	in	1 21801
!	31. DATE FILED (Month, Day,	23 199	5 Julia a	'S SIGNAT	TURE	rdall			 :			5		
														DHMH-18 Rev 1/8



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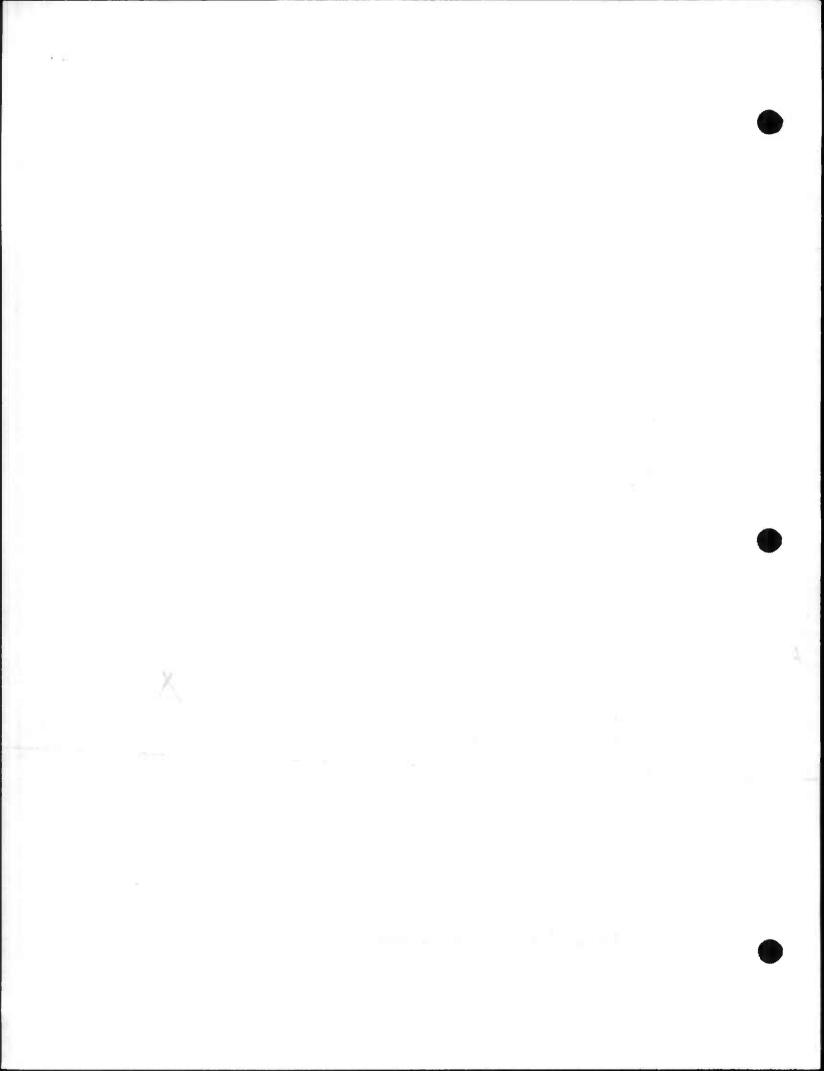
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: It liem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

									95	5 3	3621
	1 - STATE REGISTRAR	STATE OF MA	RYLAND /	DEPAR	TMENT OF I	HEALTH AN	D MEN	TAL HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Last)	EST ERN	EST AF	THU	R (A)	CASS	1MC	ate of DEATH DATH DATH		YEAR	3. TIME OF DEATH 7:45A M
	4. SOCIAL SECURITY NUMBER 131-16-9734		AGE (In yrs. lest		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HF	7. D/	ATE OF BIRTH forth, Day, Year) V 14 19			LACE (State or Foreign
TOR	98. FACILITY NAME (If not institution, give sti Anne Arundel Medi RESIDENCE OF DECEDENT	2-10-10-10	r		9b. CITY, TOWN	napoli	F DEATH		9c. COL	NTY OF DE	Arunde I
DIRECTOR	10a. STATE 10b. COUNTY	Arundel		10c. CIT	y, town or local	vidsonv	ille				10d. INSIDE CITY LIMITS?
FUNERAL	3470 Constellation	on Drive			10	21035	5			IZEN OF WI	States
BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT E FORCES? 1 IF YES, GIVE WAR	YES 2 ZW	AED O	If yes, sp	CENDENT OF HIS ecify Cuben, Me 2 NO Sp	xican, Pue	IGIN? (Specify Yes rto Ricen, etc.)	or No-	14. RACE Black, Specify	American Indian, White, atc.
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12)	ATION completed) College (1-4 or 5+)	(GA life.	e kind of v Do NOT us		est of working		16b. KIND OF BUS			
	6 17. FATHER'S NAME (First, Middle, Last) John DeJersey C	200	Depa	ar tme	ent Head	16. MOTHER'S		Eastr sı, Middle, Meiden a Harbov	Sumame)	Kodak	
TO BE	Lillian Cass	A33			ADDRESS (Street of	and Number or Re	ural Route N	lumber, City or Tow	n, State, Zi		MD 21035
	20s. METHOD OF GISPOSITION 1	val from State	20b. PLACE A	ND DATE (OF DISPOSITION (N	ame of		ATE 20c LD	CATION -	City or Tow	
	21. BIGMATURE OF FUNERAL SERVICE LICE	INSERT P	for	/	22. NAME A	ND ADDRESS OF	FACILITY	ohn M.	Taylo	r Fur	neral Home
	23. PART I. Enter the disesses, or conshock, or heart failure. L. IMMEDIATE CAUSE (Final disesse or condition resulting in death)	L L	aused the decon each line.	1		de of dying,	such as c	ardisc or respi	iratory sr	reat,	Approximats interval Batween Onset and Death
ERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OF	R AS A CONSECU	UENCE OF	7: He end m	Disc	<u> ५</u> १५				
C	PART II. Other significant conditions	contributing to de	/	Suiting	n the underlying	cause given	in Part I				YERE AUTOPSY FINDINGS
MEDICA								1 TYES 2	V	6	NAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
PHYSICIAN:		HOSPITAL:	26. PLACE	OF DEAT	H (Check only one) OTHER:						
ву рну	27. MANHER OF DEATH 1 Netural 5 Pending Investigation	26s. DATE OF INC (Month, Day,	NURY	28b. TIMI INJ	URY WO			DESCRIBE HOW II	NJURY OC	CUMED	
E E	3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF II building, etc.	LIUTY At hom . (Specify)	e, farm, s	treet, factory, offic	•	201, L	OCATION (Street a My or Town, Statu)	ind Number	r or Runal Roo	Namber,
COMPLE		IAN: To the best of my									and manner as stated.
TO BE C	296. SGMATURE AND TITLE OF CENTIFIER	l_				zec LIGENSE	HUMBER	8	29rl. DAY	PO /	25/85
	STEU BY FY TO THE	COMPLETED CAUSE		27) (Type.	Print)	()	2.			1	Zulat

31. DATE FILED (Month, Dey, Year)
OCT 2 7 1995
32. REGISTRAR'S SIGNATURE)
OCT 2 7 1995



3. TIME OF OEATH

REG. NO

2. DATE OF DEATH

1 -

STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

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October Addie Mainia 01:28 4 SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR 8. BIRTHPLACE (State or Foreign IF UNDER 24 HRS MONTHS DAYS HOURS MIN. 1 M 2 7 Jan 21, 79 Maryland 215-05-0087 1916 Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF OEATH DIRECTOR Baltimore St. Agnes Hospital Baltimore 10c. CITY, TOWN OR LOCATION 10a, STATE 10d. INSIDE CITY Baltimore Baltimore Maryland 1 YES 2X NO permit. 10e. STREET AND NUMBER 10f. ZIP. CODE 10g. CITIZEN OF WHAT COUNTRY? FUNERAL 5552 Ashbourne Road 21227 United States as the burial-transit after death. Page, 6 may be retained by the hospital or attending physician 13. WIS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—if yes, specify Cuban, Maxican, Puerto Rican, atc.)

1 □ YES 2 NO Specify: 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 14. RACE — American Indian, Black, White, atc. FORCES? 1 YES 2 2 X NO 1 Never Married 2 Married Specify: BY 3 🛱 Widowed 4 🔲 Divorced White ETED 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY esn nse (Specify only highest grade compi jo Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home 11 funeral director, page 5 should be detached Once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Clara May Watkins to or Carl H. Spurrier notffled 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 5552 Ashbourne Road Baltimore, MD 21227 Edward Cook 90 20a, METHOD OF DISPOSITION
Disposition 3 Removal from State
Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE must Loudon Park Cemetery Baltimore, MD 10-27 21. SIGNATURE OF FUNERAL SERVICE LICENSEE medical examiner 22. NAME AND ADDRESS OF FACILITY Harry H. Witzke Funeral Home, Inc. sheme a. 4112 Old Columbia Pike Ellicott City 21043 filled in by the 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate POMES shock, or heart feliure. List only one cause on each line. 10 **Onset and Death** IMMEDIATE CAUSE (Final cremation, the disease or condition SEPTIC SHOCK 24 HRS completely resulting in death) event, DUE TO (OR AS A CONSEQUENCE OF) executed burial, I MO. NEUMONIA other traumatic and CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): signed by the attending physician a Health and Mental Hygiene prior to it any, leading to immediate cause. Enter UNDERLYING 2 certificate CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 10 Injury, PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS MEDICAL AMAILABLE PRIOR TO any requires that TRANSITIONAL CELL CANCER OF THE BLADDER (STAGE 4) COMPLETION OF CAUSE 1 TYES 2 NO OF DEATH? shows a 1 TES 2 NO has been Dept. of h DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO. IN UNCERTAIN I PHYSICIAN: W. 23 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) Item THE HOSPITAL OR ATTENDING PHYSICIAN: The THE FUNERAL DIRECTOR: After this certificate In fled within 72 hours after death with the State I HOSPITAL OTHER:
4 Nursing Home 5 Residence 1 TYES 2 NO Inpetient 2 - ER/Outpatient 3 - DOA 6 27. MANNER OF DEATH 28a. OATE OF INJURY 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED Natural marked, 5 Pending 1 YES 2 NO М BY Investigation Accident 28a. PLACE OF INJURY — At home, farm, atreet, factory, offica building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) Suicide 69 6 Could not be 4 Homicide 28 Щ CERTIFIER (Check only one) 2 MEDICAL EVALUATION OF THE BEST OF my knowledge, death occurred at the time, data and place, and due to the cause(e) and menner as steted. tem 29a. CERTIFIER COMPI TO THE HOSPITAL (
TO THE FUNERAL D
DE filed within 72 h
IMPORTANT: If II 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d, DATE SIGNED (Month, Day, Year) BE. L'Ellis PGY-3 PO 7532 23/95 (MEDICAL RESIDENT) 2 30, NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) AGNES AVENUE, BALTIMORE, MARYLAND HOSP 910 CATON 32. REGISTRAR'S SIGNATURE 31. DATE FILEO (Month, Day, Year) **OCT 26** DHMH-16 Rev 1/89

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

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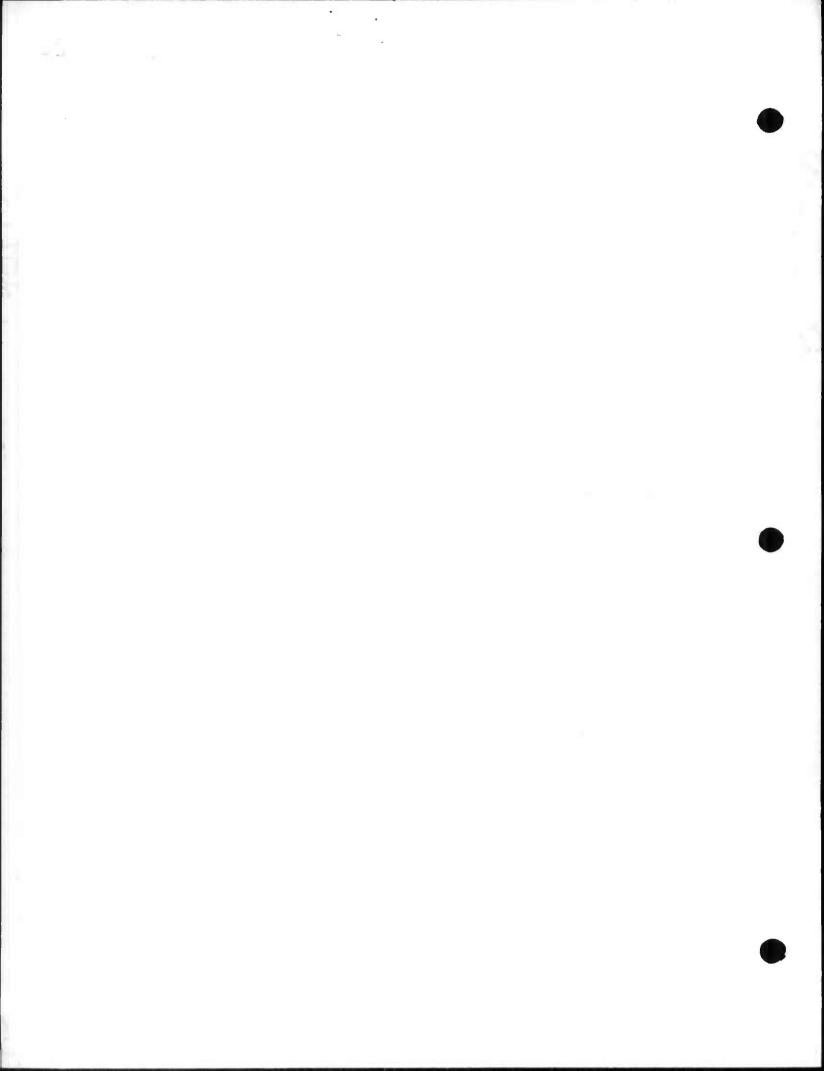
DIVISION OF VITAL RECORDS, P.O. BOX 68760

) THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Z4 hours after death. Page 6 may be retained by the hospital or attending physician.	HE FUNRAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit nermit Pages 1 2 3 chould	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	MPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
TO THE !	TO THE F	be filed w	IMPORT

BALTIMORE, MARYLAND 21215-0020

FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CE	RTIF	CATE O	F DEATH	REG. N	0.		
	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF DEATH			3. TIME OF DEATH
	Gordon K	enneth		Chil	coat,	Sr.	October	25. 19	YEAR QG	8:30 AM M
	4. SOCIAL SECURITY NUMBER	5. SEX	S. AGE (In yrs. lesi		IF UNDER 1 YEAR		7. DATE OF BIRTH			PLACE (State or Foreign
	213 03 0773	1 🔯 M 2 🗌 F	75		MONTHS DAY		(Month, Day, Year) May 2, 19		Countr	yland
~	9a. FACILITY NAME (If not institution, give stre	eet and number)				N OR LOCATION OF DI		9c. CDUN		
2	519 Woodbury Way				E	el Air			Ha	rford
E E	10a. STATE 10b. COUNTY			10c, CITY.	TOWN OR LO	CATION				10d. INSIDE CITY
DIRECTOR		larford			Bel A					LIMITS?
FUNERAL	100. STREET AND NUMBER 519 Woodbury Way	,				101. ZIP CODE 21014		10g. CITIZ	US.	WHAT COUNTRY?
5		12. WAS DECEDENT	EVER IN U.S. ARI	MED	13. WAS D	ECENDENT OF HISPA!	HC ORIGIN? (Specify Y	es or No-	14. RACE	- American Indian,
BY F	1 Never Married 2 Married 3 Wildowed 4 Divorced	FORCES? 1X IF YES, GIVE WAY	OR DATES	ю		specify Cuban, Maxica ES 2 X NO Specif			Speci	White
8	15. DECEDENT'S EDUCA	ATION	16a, DE	CEDENT'S U	ISUAL OCCUPA	TION	16b. KIND OF B	USINESS/INDL	USTRY	WILCO
	(Specify only highest grade of Elementary/Secondary (0-12)	College (1-4 or 5+)	(Gi	ve kind of wo Do NOT use	retired.)	most of working upervisor	And the second second			
COMPLETED	12		Com	merci	al Ser	Vices	El	ectric		
Š	17. FATHER'S NAME (First, Middle, Last)			_			ME (First, Middle, Maide	n Sumame)		
BEO		Chilcoat				Marie		midt		
	19a. INFORMANT'S NAME (Type/Print)		19b	MAILING A	ADDRESS (Street	t and Number or Rural	Route Number, City or To	wn, State, Zip	Code)	
2	Nora A. Chilcoat						l Air, Md			
	20a. METHDD OF DISPOSITION 1X Burlei 2 Cremetion 3 Pemov		20b. PLACE A	ND DATE OF	DISPOSITION			OCATION — C		wn, Stata
	4 Donation 8 Other (Second	ART From State	Bel A	natory or oth	morial	Gardens	10-28-95	Bol.	Dir	БМ
	21. SIGNATURE OF FUNERAL SERVICE LICE	ASSET (C)	7		22. NAME	AND ADDRESS OF FA	CILITY			
	Nous IV	11/11/2	/	1/						Home, P.A.
H	22 PART I Fotos the disease	IVY as	m		50 W	. Broadwa	y St., Be	l Air,	_Md	21014
	23. PART I. Enter the diseases, or co ahock, or heart failure. Li	lat only one cause	on each line.	th. Do no	ot anter the r	node of dying, auc	h aa cardiac or rea	piratory arre	est,	Approximata Interval Between
	IMMEDIATE CAUSE (Finel disease or condition	477	. 4	0		4	1			Onset and Death
	resulting in death)	450	henic	Ca.	rdion	yopat	7			7 years
1 1		DUE TO (D	R AS A CONSEC	UENCE OF)	:					
3	Sequentially list conditions, b.									
Ě	If any, leading to immediate cause. Enter UNDERLYING	DUE 10 (D	AS A CONSEO	UENCE DF)	*					
CERTIFICATION	CAUSE (Disease or Injury C.	DUE TO 40	R AS A CONSEO	HENCE OF						
Ē	that initiated events resulting in death) LAST	502 10 (0	II AS A CONSEC	DENCE OF).	•					
핑	d.									
	PART ii. Other eignificent conditions	contributing to de	eeth but not re	euiting in	the underly	ing ceuse given in	Part I. 24a. WAS A		24b.	WERE AUTOPSY FINDINGS
DICAL	- Rheundin F		ilel hood	7,	mitr	al Stene	S IS PERFO	RMED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE
MEC	(pitrul Valve P	rosthosi	s - Feb	,95)	Chron	ic Atrial	Eibeille	100		OF DEATH?
	CATTON Valve Prosthosis - Feb, 95), Chronic Atrial Eibrillation. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN									T TES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL				(Check only on		• • •			
S		HOSPITAL:	B/Outpetlant 2	DO4	OTHER:	ome 5 Residence				
Ě	27. MANNER OF DEATH	28a. DATE OF IN		28b. TIME		NJURY AT	28d. DESCRIBE HOW	IN HIRV OCC	HOED	
	Natural 5 Pending	(Month, Day,	Year)	INJU	RY \	YORK?	28d. DESCRIBE NOW	INJUNI OCCI	ONED	
B	2 Accident Investigation 3 Suicide & Could not be	28e. PLACE OF	NJURY — At hor	ne form etr			204 I OCATION (Com-			
	4 Homicide determined	butlding, at	c. (Specify)	170, 1811III, SLI	eet, ractory, or	iles	28f. LOCATION (Street City or Town, State	and Number o	or Hural H	loute Number,
W.	29a. CERTIFIER									
COMPLET	(Check only one) 2 MEDICAL EXAMINER:									and manner or stated
	29b. SIGNATURE AND TITLE OF CERTIFIER	-4	,		, opinion					
띪	AND STORATORE AND TITLE OF CERTIFIER	111	6	1		29c. LICENSE NUN	18ER	29d. DATE	SIGNED	(Month, Day, Year)
2	30. NAME AND ADDRESS DF PERSON WHD	COMPLETED SAUCE	DE DEST	1077		1 233		100	- / 6	اردار دع ساعط
	J. KEVIN LYN	CH MI			かれ	Ave.	Bel Air,	md.	21	BER 25, 199
	31. DATE FILED (Month, Day, Year)	20. REGISTRARY	SIGNATURE	el						
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this cartificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit nermit. Pages 1 2, 3 should
be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF OEATH 3. TIME OF DEATH BEATRICE F. COHEN OCTOBER 24 1995 10:30PM 4. SOCIAL SECURITY NUMBER 6. AGE (In vrs. lest birthday) IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year IF UNDER 1 YEAR 8. BIRTHPLACE (State or Foreign Country) 061-05-8546 1 M 2 X F DAYS HOURS BRIN. 92 YRS SEPT. 3,1903 NEW YORK 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR MONTGOMERY GENERAL HOSPITAL OLNEY MONTGOMERY RESIDENCE OF DECEDENT 10a. STATE 10c. CITY, TOWN OR LOCATION 10b. COUNTY 10d. INSIDE CITY MARYLAND MONTGOMERY SILVER SPRING 1 TYES 2 NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 14510 HOMECREST ROAD #4015 20906 UNITED STATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— II yes, specify Cuben, Mexican, Puerto Ricen, stc.) 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 A NO 14. RACE — American Indian, Black, White, etc. 1 Never Merried 2 Merried IF YES, GIVE WAR OR DATES 1 TES 2 NO BY Specify: Specify: WHITE 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Sn (Give kind of work done during life. Do NOT use retired.) Elementery/Secondary (0-12) College (1-4 or 5+) SECRETARY CHILDRENS APPAREL 17. FATNER'S NAME (First, Middle, Last) 16. MOTNER'S NAME (First, Middle, Maiden Surname) SAMUEL COHEN ANNIE JOSEPHSON BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 SHARON LIEBERMAN 320 GREENHILL WAY - SILVER SPRING, MD. 20904 20e. METHOD OF DISPOSITION

1 XBurlel 2 Cremetion 3 Removal from State
4 Donation 5 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — Cify or Town, State DATE KING DAVID MEMORIAL GARDEN 10/26 Donation 5 - Other (Specify) _ FALLS CHURCH, VIRGINIA 21 SIGNATURE OF FUNERAL SERVICE LICENSES 22. NAME AND ADDRESS OF FACILITY DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE-ROCKVILLE, MD. 20852 23. PART I. Enter the diseases, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdiac or reepiratory arrest, Approximate shock, or haert fallure. List only one cause on each line. Interval Betwe IMMEDIATE CAUSE (Finei Opset and Death disease or condition_ eav MIC resulting in death) DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF). that initiated eventa resulting in death) LAST PART ii. Other, algnificent conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE 24a, WAS AN AUTOPSY PERFORMED? 1 TES 2 THE OF DEATN? an VCha 1 YES 2 WHO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO [1] PHYSICIAN: JUNCERTAIN [25. WAS CASE REFERRED 15 MEDICAL 26. PLACE OF DEATN (Check only one) HOSPHAL: OTHER: 1 TES 2 1 Department 2 ER/Outpatient 3 DOA 4 - Nursing Home 5 - Reeldence 8 - Other (Specify) 27. MANHER OF DEATH 28e. DATE OF INJURY 28b. TIME OF INJURY 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED 1 Wetural 5 M ВҰ 1 YES 2 NO Accident Investigation 28s. PLACE OF INJURY — Al home, lerm, street, lectory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED Could not be 4 Nomicide determined 29e. CERTIFIER 1 DERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(e) and manner as stated. 2 MEDICAL EXAMINER: On the beels of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 296. SHAMATURE AND TITUE OF CERTIFIER

LICENSE NUMBER

BE 2

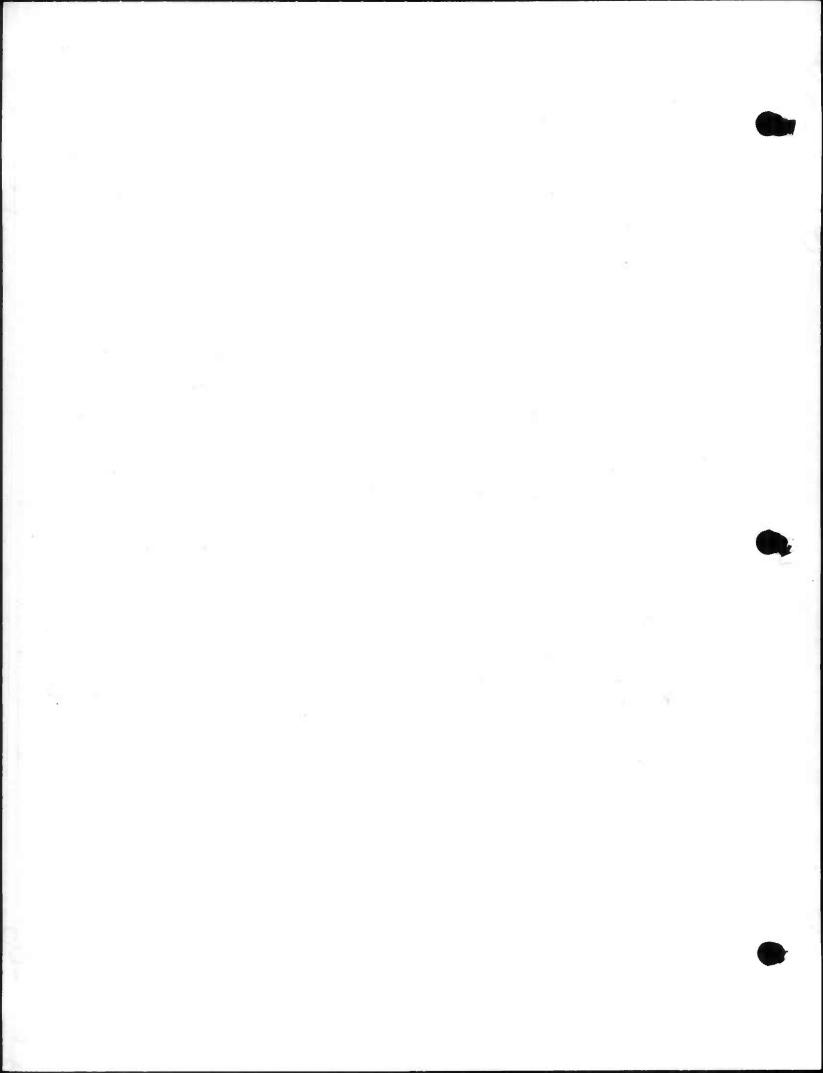
31. DATE FILED (Month)-Day, Year)

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1995

30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32 REGISTRAR'S SIGNATURE Davidson Revolate 29d, DATE SIGNED (Month, Day,



Pages 1, 2, 3 should

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	TO THE HOSPITAL OR ATTENDING PHYSICIAN; The law requires that the death certificate be executed within 24 hours	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or re	IMPORTANT: If Item 28 is marked, or item 23 shows any Injury, or other traumatic event, the med
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FOR STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3 TIME OF DEATH DAY 1995 YEAR Richard Oct. Eugene Christian 2:30 p. 7. DATE OF BIRTH
(Month, Dey, Year)
May 28,1921 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign Virginia 577-22-6660 1 M 2 | F 74 9s. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 804 Wade Avenue Rockville MONTGOMERY RESIDENCE OF DECEDENT 10b. COUNT 10c. CITY, TOWN OR LOCATION 10a. STATE 10d. INSIDE CITY Maryland Rockville Montgomery 1 X YES 2 | NO FUNERAL 10a. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? 107 ZID CODE 804 Wade Avenue 20851 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 Q YES 2 \(\text{NO}\) NO IF YES, GIVE WAR OR DATES WORLD WAR # 2 11, MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-if yea, specify Cuben, Maxican, Puerto Ricen, etc.) 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married 1 YES 2 NO Specify: BY 3 Widowed 4 Divorced Black COMPLETED 16s. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only It Elementery/Secondary (0-12) 90 (1-4 or 5+) 5 Plus Water Proofer Bethesda Asphalt Co. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname James H. Christian Pauline V. Brooks 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code (Wife) 2 804 Wade Ave, Rockville, Md Christian Mrs Gladys E. 20a. METHOD OF DISPOSITION DATE 20c. LOCATION -- City or Town, State Buriel 2 Cremetion 3 Removal from State Parklawn Memorial Cem. 10/28 Donation 5 - Other (Specify) Rockville, Md 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Snowden Funeral Home P.A. 20850 246 N. Washington St. Rockville, Md 23. PART I. Enter the diseases, or complications that caused the deeth. Do not sater the mode of dying, such as cardiac or respiratory street, abock, or heart failure. List only one cause on each line. intarval Between Onaet and Death IMMEDIATE CAUSE (Final disease or condition Acul Myocandial Mindian IMMEDIATE reaulting in death) DUE TO (OR AS A CONSEQUENCE OF): 1985 CORUNACIO CERTIFICATION Sequentially list conditiona, DUE TO (OR AS A CONSCOUENCE OF): If any, leading to immediate cause. Enter UNDERLYING Hyper turin 1980 CAUSE (Disease or injury DUE TO OR AS A CONSEQUENCE OF): that initiated events reauiting in death) LAST PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? million PERFORMED? Mumtinsin 1 - YES 2 NO IDSU/ICIMU 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMPLER?
1 1 YES 2 NO 26. PLACE OF DEATH (Check only one) OTHER:
4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 - ER/Outpatient 3 - DOA 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK?
1 YES 2 NO 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending Investigation BY 2 Accident 28s. PLACE OF INJURY — At home, ferm, strest, factory, office building, stc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be COMPLETED 4 Homicide 29e. CERTIFIER
(Check only one)

2 MEDICAL EXAMINED: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner se stated. 2 MEDICAL EXAMINER: On the basts of examination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and menner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIES 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) Want D 17656 10-26-95 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) WOODWARD, M.D 5530 WISCONSIN AVE. #550, CHENY CHASE, MO 20815 July Dundler Randell 31. DATE FILED (Month, Day, Year) 26 1995

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

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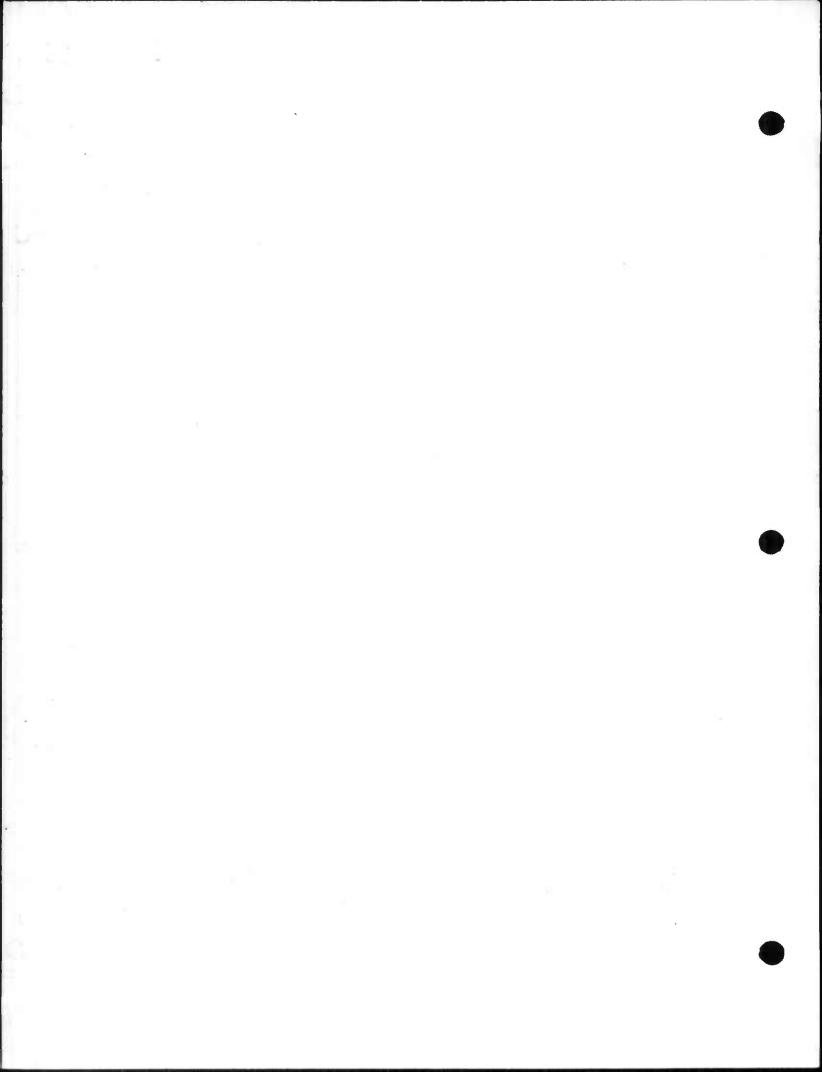
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DATE FILED (Month, Day, Year)
OCT 26 1995

	REGISTRAR		CEI	RTIFICA	ME OF			POPES INC.			
	1. DECEDENT'S NAME (First, Middle, Last,)				DEATH		REG. NO.		3	. TIME OF DEATH
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	4. SOCIAL SECURITY NUMBER	5. SEX 6.	AGE (In yrs. lest b		NDER I YEAR	IF UNDER 24 HRS.	7 DATE	OF BURTH	1.	BIRTHPL	ACE (State or Forei
	241-56-1471	1 🗆 M 2 😡 F	54	YRS. MONT	HB DAYS	HOURS MIN.	NOV	21,19	40	(Country)	Caroli
	90. FACILITY NAME (If not institution, give	street and number)		9b.	CITY, TOWN	OR LOCATION OF DI			e. COUNTY	OF DEA	TN
OR	Frederick Memo	rial Hosp	ital		Fre	ederick			FRED	ERI	CK
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT	TY	T	10c, CITY, TOY	M 00 100	TION					
E		derick			ederi						Dd. INSIDE CITY LIMITS?
	10e. STREET AND NUMBER	GELICK		FIE		I. ZIP CODE			IO- CITIZEA		YES 2 N
FUNERAL	1418 Taney Av	#102			"	2170]	1	S		S.A	
N	11. MARITAL STATUS	12. WAS DECEDENT EV	ER IN U.S. ARME	ED T	13. WAS DE	CENDENT OF HISPAN		7 (Specify Year or			- American Indian.
	1 Never Married 2 Married	FORCES? 1	YES 2500		II yes, s	pecify Cuben, Mexica 3 2 X NO Specifi	an, Puerto F	tican, etc.)	NO- 14.	Black, V	Vhite, etc.
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iu	Elementary/Secondary (0-12)	College (1-4 or 5+)	Ilfe. Di	o NOT use retin	ed.)	out or working					
COMPL	10th			lerk			_	.& R.		k	
	17. FATNER'S NAME (First, Middle, Last)					18. MOTHER'S NA			meme)		
BE	Unknown 190. INFORMANT'S NAME (Type/Print)						cie l				
2	Vernon R. Coope	(Husband)				and Number or Flural I					D 0170
	200. METHOD OF DISPOSITION	er, sr.				Ave.,	_	_			
	1 Suriel 2 Cremetion 3 Ren 4 Donation 5 Other (Specify)	noval from State	206. PLACE AND COMMENTS. C	tory or other pie	POSITION (N.	ame of	DATE				
	21. BIGNANTRE OF FUNERAL SERVICE L	ICENSEE /	Falkia				10/	20 RO	CKVI	тте	, MD
SNOWDEN FUNERAL HOME, P.A.											
_	J. you	0/0 100	wire	u	ROCK	VILLE,	MD	20850			
	23. PART i. Enter the diseases, or	complications that cal					TID				
	shock, Dr'fheart failure.	List only one cause t	on each line.		nter the mo	ode of dying, auc	h aa card	iac or reapirat			Approximate
	IMMEDIATE CAUSE (Fine)	List only one cause t	on each line.		nter the mo	ode of dying, auc	h aa card	iac or reapirat		*	Approximate interval Bets Onset and E
	SHOCK, DIMIEST TAILUTE.	e. Chro	me l	Obst.	nter the mo	ode of dying, auc	h aa card	iac or reapirat	ory arrest	in	Onset and E
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SICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	rificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit, Pages 1, 2, 3 should be State Dent. of Health and Mental Hyolene prior to burial, cremation, or removal.	d, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
executed within 24 hours after death. Page 6 mil	n and completely filled in by the funeral director, to burial, cremation, or removal.	imatic event, the medical examiner must
he law requires that the death certificate be	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the field within 72 hours after death with the State Dect, of Health and Mertal Hydlene prior to burial, cremation, or	m 23 shows any injury, or other train
TO THE HOSPITAL OR ATTENDING PHYSICIAN: TI	TO THE FUNERAL DIRECTOR: After this certificate the filed within 72 hours after death with the Stati	IMPORTANT: If item 28 is marked, or iter

	FOR 1 - STATE REGISTRAR	STATE OF M		/ DEPAR					MENTAL	HYGIEN REG. NO.	_			
1	1. DECEDENT'S NAME (First, Middle, La	st)					D		2. DATE O	F DEATH			3. TIME OF D	EATH
- 1	GERALDINE	LEF	7		СП	EUNC	,		OCT	OBER [™]	19	199		
- "	4. SOCIAL SECURITY NUMBER		6. AGE (In yrs.	last birthday)		T YEAR	IF UNDER	24 HRS.	7. DATE OF	F BIRTH			IPLACE (State o	
	207-12-9957	1 □ M 2 🙀 F	71	YRS.	MONTHS	DAYS	HOURS	MIN.	Sept.	Day, Year) . 18,	1924	Counti	nnsylv	
ВО	9e. FACILITY NAME (If not Institution, gi AUGUST & GEO	ve street end number) RGIA AVE				,	SPI					NTGC	DMERY	
DIRECTOR	RESIDENCE OF DECEDENT 10e. STATE 10b. COU				Y. TOWN									
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	Maryland M	lontgomery) 5	ilve						1		1 VES 2	2.0
FUNERAL	1906 Everest St	reet				101	ZIP CODE				tog. Cit	USA	WHAT COUNTRY	7
S.	11. MARITAL STATUS	12. WAS DECEDENT FORCES? 1							IIC ORIGIN?	(Specify Year	or No-	t4. RACI	E — Americen I k, White, atc.	ndian,
BY	1 Never Married 2 Merried 3 Wildowed 4 Divorced	IF YES, GIVE W					2 X NO			cen, etc.,		Spec		e
G	15. DECEDENT'S I (Specify only highest g.	EDUCATION	16e.	DECEDENTS	USUAL O	CCUPATIO	ON .		16b. F	(IND OF BUS	SINESS/IN	DUSTRY		
Fi	Elementary/Secondary (0-12)	College (1-4 or 5 +		(Give kind of life. Do NOT u	work done se retired.)	auring mo	st of workin	g						
MPI	12			Homem	aker					Own H	ome			
COMPLETED	17. FATHER'S NAME (First, Middle, Last)						18. MOTH	IER'S NA	ME (First, Mic	ddle, Maiden	Sumeme)			
BE	Richard Lee						Ma	ary l	Nevil	le_				
5	194. INFORMANT'S NAME (Type/Print)			196. MAILING										
	Leslie Cheung	5					_		_	er Sp			20902	2
	20e. METHOD OF DISPOSITION 1 25 Burlal 2 Cremation 3 F 4 Donation 5 Other (Specify)	lemoval from State	cometery. Wash	CEAND DATE	of bispos other place n Na	tion	al Ce	/24/9 emet	95 DATE			nd, I		
	21. SIGNATURE OF FUNERAL SERVICE	LICENSEE	1		22.	NAME A	D ADDRES	S OF FA	CILITY				-	
	* Mark	, //ille	ll										e, Inc. .MD 209	
	23. PART I. Enter the diseases,	or complications that	caused the	death. Do									Арргох	lmata
	IMMEDIATE CAUSE (Final disease or condition				2 1									Between and Death
	resulting in death)	MULTI DUE TO	OR AS A CON											
NO	Sequentially list conditions,	b.	OR AS A CON	SECULENCE O	ID.									
AT	If any, leading to immediate cause. Enter UNDERLYING	002 10 (On AS A CON	SEOUENCE C	rr):									
윤	CAUSE (Disease or injury that initiated events	c. DUE TO (OR AS A CON	SEDUENCE O	F):			_					+	
CERTIFICATION	reaulting in deeth) LAST	d												
	PART II. Other algnificent condi	tions contributing to	death but no	ot resulting	In the u	nderlyln	T COURS C	ilven lo	Part I	24a. WAS AN	Vadottia	241	. WERE AUTOPS	V EINDINGS
SAL			300 m	or readming	m the di	i ragi i y ii r	a couse ?	Non HI		PERFOR	RMED?	240	AVAILABLE PRI	OT PO
									-	1 YES 2	. □ NO		OF DEATH?	
Σ	DID TOBACCO USE CO	NTRIBLITE TO CAL	ISE OF D	FATH Y	FS []	NO F	LINC	ERTAIL					1 YES 2	NO
AN	25. WAS CASE REFERRED TO MEDICA			LACE OF DEA] 0140	LKIAII						
PHYSICIAN: MEDI	EXAMINER? t X YES 2 □ ND	HOSPITAL:			OTHE	D.		.14:	8 X Other		SCEN	T I		
Η	27. MANNER OF DEATH	28s. DATE OF	INJURY	28b. TII			URY AT	reiderice		RIBE HOW			()E	Hrus
	t Netural 5 Pending	(Month, Da		812	JURY M	t 🗌	PRK7	ND	150	ESTIL	Du (Mru	uc 134	MOTON
) BY	2 Accident Investigati 3 Suicide 6 Could not	28s. PLACE OF	FINJURY - A	t home, lerm,	atreet, fec	tory, offic	•		28f. LOCAT	TION (Street	end Numbe		Route Number,	(0
Ĕ	4 Homicide datermine		ntc. (Specify)	SOWA	N					TOWN, State)		inn	IN Mais	Thurs
۳	29e. CERTIFIER t CERTIFYING PI	YSICIAN: To the best of				time dete	and alass	and due				11/10	Off. BONO	TEN PACIE
COMPLETED		MINER: On the basis of ax											e) and manner :	e stated.
	29A SIGNATURE AND TITLE OF CERT						29c. LICE							
BE	Ways to the	01/6/18						.C.I					O (Month, Day, Ye	0
2	30. NAME AND ADDRESS OF PERSON	WHO COMPLETED CAUS	E OF DEATH (ITEM 27) (Type	e, Print)								ER 20,	
	MARYPONDO	V-1000es	e ans	111 P	enn	Sti	ceet	, В	altir	more	, Ma	ryl	and 21	201
	31. DATE FILED (Month, Day, Year) OCT 25 199	5 Julia Da	R'S SIGNATUR	irdall										
	- 100	U_AI	-	0										

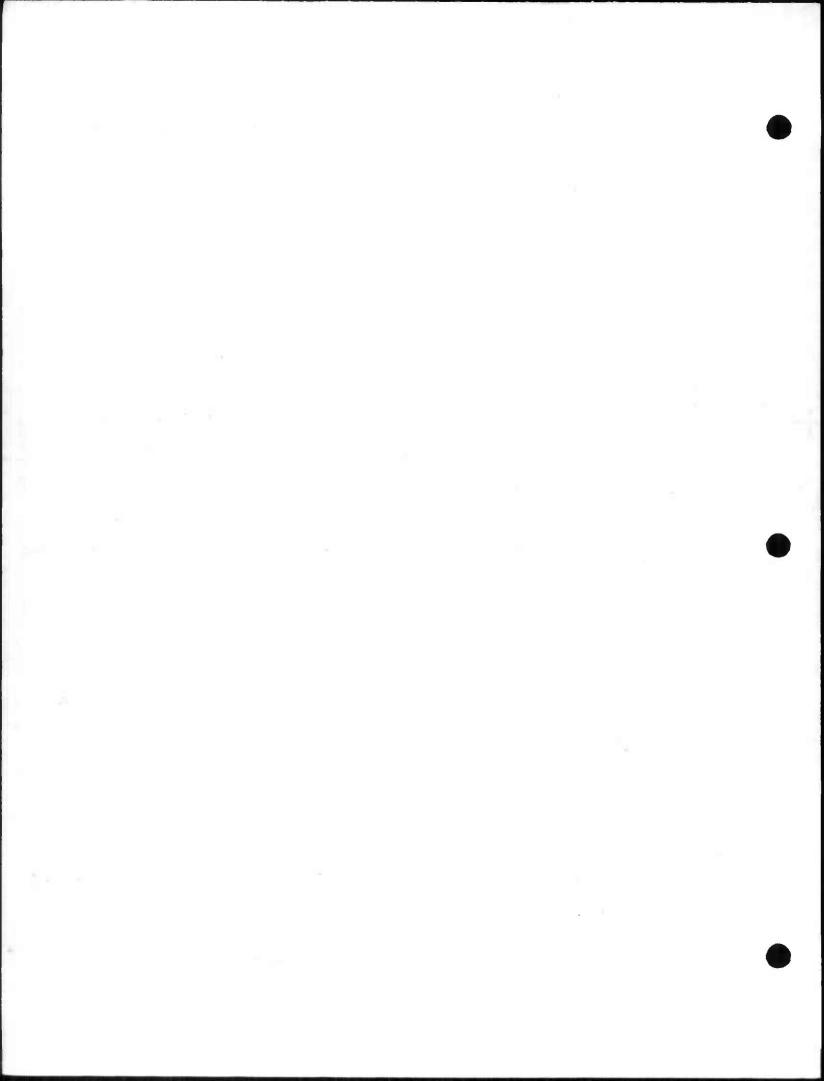
FOR STATE REGISTRAR

1 -

r attending physician.	use as the burial-transit permit. Pages 1, 2, 3 should		
that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or	ed by the attending physician and completely filled in by the funeral director, page 5 should be detached for u	th and Mental Hygiene prior to bunal, cremation, or removal.	d, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
) THE HOSPITAL DR ATTENDING PHYSICIAN: The law requir	TO THE FUNERAL DIRECTOR: After this certificate has been si	thin 72 hours after death with the State Dept. of Hi	MPORTANT: If item 28 is marked, or item 23 show
D THE	TO THE	be filed >	IMPORT

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEDENT'S NAME (First,		VIO		0.111	`			2. DATE OF MONTH	0	AY	YEAR	3. TIME OF DEATH
	CHARLE		Y.P.		CHI	J			OCTOB	ER	19 19	95	2000 M
	4. SOCIAL SECURITY NUME		5. SEX	6. AGE (In yrs. les		MONTHS DAYS		MIN.	7. DATE OF (Month, D	ey, Year)		Count	IPLACE (State or Foreign ry)
	098-46-403		1 🔀 M 2 🗆 F	65	YRS.				Nov.	29,			
œ	90. FACILITY NAME (# not in Shady Grove			nital		96. CITY, TOW	ville		EATH			NTY OF D	
<u>ē</u>	RESIDENCE OF DEC		ILIST HOS	pitai		ROCK	ATTTE				MOI	tgoπ	lery
DIRECTOR	10a. STATE	10b. COUNTY	Y		10c. CITY	r, TOWN OR LO	CATION						10d. INSIDE CITY
	Maryland	Monte	gomery		R	ockvil.	le						LIMITS? 1 YES 2 NO
AL	10e. STREET AND NUMBER						101. ZIP CO	DE			10g. CIT	IZEN OF	WHAT COUNTRY?
FUNERAL	6349 Winde	rmere					208	52			Ū	JSA	
5	11. MARITAL STATUS 1 ☐ Never Married 2 🂢	Married	FORCES? 1	T EVER IN U.S. AR	MED	13. WAS D	ECENDENT specify Cut	OF HISPAI	NIC ORIGIN? (Specify Yearn, etc.)	a or No—	14. RACI Black	E — American Indien, k, White, etc.
B≺	3 Widowed 4 Divo		IF YES, GIVE V	WAR OR DATES		1 🗆 Y	ES 2 X N	Specif	fy:			Spec	inese
	15. DEC	EDENT'S EDU	CATION	16e. DE	CEDENT'S	USUAL OCCUPA	TION	_	16b. Ki	ND OF BU	SINESS/INI		These
E	(Specify only Elementary/Secondary (0	y highest grade 1-12)	College (1-4 or 5	+) (G	Do NOT us	vork done during e retired.)	most of worl	king					
AP.	12		4		elf-e	mploye	đ		R	esta	urant	-	
COMPLETED	17. FATHER'S NAME (First, M						1111		AME (First, Mid	dle, Maiden	Surname)		
BE	Ching-Tong						P	ao-Si	hu Chu				
2	19a. INFORMANT'S NAME (1					ADDRESS (Street				-			11 20052
	Wendy H. Ch							CIFC.					land 20852
	1 Buriel 2 Crematic	n 3 🗆 Rem	oval from State	cemetery, cre	matory or of	prosposition the place).	(Name of	l _r	1		Level 1		Maryland
	21. SIGNATURE OF THERA		CENSE!	Idiki	awii ii								neral Home
	16	4	fort-	LAM	hor	/1180	0 New	Ham	pshire	Ave	nue		
	June		nene	1 Loca	ME				, Mary				
		eert fallure.	List only one cer	use on each line	etn, Do n	ot enter the i	node or d	ying, auc	en aa cardia	c or resp	aratory ar	rest,	Approximate Interval Between
	IMMEDIATE CAUSE (Fir disease or condition	nal	(-000	100	(263 10							Onset and Death
	resulting in deeth)	-	DUE TO	OR AS A CONSE	DUENCE OF		MA					_	six months
z			Liv	tric (OR AS A CONSE Er [NET.	ASTAS!	EC						
CERTIFICATION	Sequentially list condit if any, leeding to imme	diate	DUE TO	(OR AS A CONSE	DUENCE OF	7:							,
S	Cause, Enter UNDERLY CAUSE (Disease or Inju		с.										
F	that initiated events resulting in deeth) LAS	т П	DUE TO	(OR AS A CONSE	DUENCE OF	7):							
EH			d							_			
	PART II. Other algnifice	ent condition	a contributing to	deeth but not r	esulting i	n the underly	ing cause	given in	Part I. 2	In. WAS AN	AUTOPSY	24b	. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO
MEDICAL									1	YES :	2 NO		COMPLETION OF CAUSE OF DEATH?
ME											, -		1 TYES 2 NO
ž	DID TOBACCO U		RIBUTE TO CA				-	CERTAI	N 🗆				
PHYSICIAN:	25. WAS CASE REFERRED TO EXAMINER?	O MEDICAL	HOSPITAL:	28. PLAC	E OF DEAT	H (Check only of	10)						
IYS	1 TYES 2 NO		1 Inpetient 2 I			4 - Numing H		Rasidence					
	1 Natural 5	Pending	(Month, E		28b. TIM	URY	INJURY AT WORK?	Пип	28d. DESCF	MBE HOW	INJURY OC	CURED	
ВУ	2 Deutstale	Investigation	26e, PLACE (OF INJURY — At he	me, term, a				281. LOCATI	ON (Street	and Numbe	r or Rural	Route Number,
COMPLETED		Could not be determined	building	atc. (Specify)					City or	Town, State)		
, E	29e. CERTIFIER (Check only	TIFYING PHYSI	ICIAN: To the best of	my knowledge, de	ath occum	ed at the time, d	ata and plac	en and due	e to the cause	(s) and ma	Door se ste	ted	
ME	(0)												e) end manner ee stated,
ECC	29b. SIGNATURE AND THE	9	Λ					CENSE NU					(Month, Day, Year)
0	-	149	Nam				D:	256	35				m 19,1995
2	30. NAME AND ADDRESS OF	F PERSON W	O COMPLETED CAU	SE OF DEATH (ITE	М 27) (Туре,	Priot	-						
	30. NAME AND ADDRESS OF	APLA	n, md	18111 b	ince	. Kr.J.	PDR	. 0	LNS	J. M	D S	083	~
- 1		Money	22 DECISTO	D'S SIGNATURE									
	31. DATE FILED (Month, Day,		J. A.	AR'S SIGNATURE	1 11								



DHMH-16 Rev 1/89

BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIPECTOR

DIVISION OF VITAL RECORDS, P.O. BOX 68760

AL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	L DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should bours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	is marked
TO THE HOSPITAL DR ATTENDING P	TO THE FUNERAL DIRECTOR: After this be filed within 72 hours after death with	IMPORTANT: If item 28 is mar

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

FOR STATE REGISTRAR		STATE OF MARY				EALTH AND	MENTA	L HYGIEN	E		
1. DECEDENT'S NAME (First,	Middle, Lest)							OF DEATN			TIME OF DEATN
PATRICIA C	ALOMERI	S					Octo	ber 20		5	8:17 A M
4. SOCIAL SECURITY NUME	ER 5	SEX 6. AG	E (In yrs. lest birthd		R t YEAR	IF UNDER 24 HRS.	7. DATE	OF BIRTH		BIRTHPL	ACE (Stete or Foreign
578-34-1682	1	□ M 2 💢 F	66 YR	S. MONTHS	DAYB	HOURS MIN.		1 2 . 1	929 N	orth	Carolina
9a. FACILITY NAME (If not in	stitution, give stree	t and number)	00	9b, CIT	Y, TOWN O	R LOCATION OF D			9c. COUNTY		
10402 Churc		у		L	aure1				Howa	rd	
10e. STATE	10b. COUNTY		10c.	CITY, TOWN	OR LOCATI	ON				10	d. INSIDE CITY
Maryland	Howar	d		Laure	1					1	LIMITS?
10e. STREET AND NUMBER					101.	ZIP CODE			10g. CITIZE	N OF WHA	AT COUNTRY?
10402 Churc	hill Wa	ıv				20723			Unite	d St	ates
11. MARITAL STATUS		2. WAS DECEDENT EVER		13		ENDENT OF HISPA				. RACE -	American Indian.
1 Never Married 2 3 Widowed 4 XXDivo		FORCES? 1 [YE IF YES, GIVE WAR OR				city Cuben, Mexico 2 XNO Specif		Rican, etc.)		Specify:	White White
	EDENT'S EDUCAT		16s. DECEDEN	T'S USUAL (OCCUPATIO	N	166	KIND OF BUS	SINESS/INDUS	TRY	***************************************
Elementary/Secondary (I	y highest grade co	mpleted) College (1-4 or 5 +)	(Give kind	of work done of use retired.	e during mos)	st of working					
12		2	Buyer					Cloth	ing In	dust	ry
17. FATHER'S NAME (First, M	liddle, Last)					18. MOTHER'S NA	AME (First,	Middle, Maiden	Surneme)		
Nicholas T	riantis					Evangel	ine	Baicou			
190. INFORMANT'S NAME (19b. MAII	LING ADDRES	SS (Street el	nd Number or Rurel			n, State, Zip Co	ode)	160
Eva Theolog	gus		1040	2 Chu	rchi	ll Way,	Laur	el, Ma	ryland	1 207	23
200. METNOD OF DISPOSIT	ION		Ob. PLACE AND DA	ATE OF DISPO	SITION (Na	ma of	DAT		CATION - CIT		
1 X Buriel 2 Cremetic 4 Donation 8 Other		al from State	Gate of	Heave	n Cer	netery	10/	23 Sil	ver Sp	oring	, Maryland
21. SIGNATURE OF FUNERA	L SERVICE LICEN			22	. NAME AN	D ADDRESS OF FA				-	
No.	X	0 01	111	Hi	nes-l	Rinaldi	Fune	ral Ho	me, Ir	nc.	
Vien	e	MI	lin								Spring, MD
23. PART i. Enter the d shock, or h	esrt fallure. Lie	mplicetions that ceus et only one ceuse or	eech line.	DD not ente	er the mo	de of dyling, auc	ch as car	diac or reap	ratory arres	st,	Approximata interval Batween
IMMEDIATE CAUSE (FI											Onset and Death
disease or condition resulting in death)	→ a	RECTAL CA									25 Months
		DUE TO (OR A	S A CONSEQUENC	E OF):							
Sequentially list condit	lons. b.	2015 72 102 1									
if sny, leading to imme	diete	DUE TO (OR A	S A CONSEQUENC	E OF):							
CAUSE (Disease or Inju		DUE TO (OR A)	S A CONSEQUENC	E OF):							
that initiated events resulting in death) LAS	т										
	d.										
PART II. Other significa	ont conditions	contributing to deeti	but not result	ing in the u	underlylng	ceuse given in	Part L	24a. WAS AN PERFO			ERE AUTOPSY FINDINGS
								1 TYES 2		C	OMPLETION OF CAUSE F DEATH?
											☐ YES 2 ☐ NO
DID TOBACCO L	ISE CONTRI	BUTE TO CAUSE	OF DEATH	YES 🗆	NO [UNCERTAI	NX				
25. WAS CASE REFERRED 1	O MEDICAL		26. PLACE OF	DEATN (Chec	k only one)						
EXAMINER?		HOSPITAL:	utpetient 3 🗆 DC	OTHE DA 4 N		e 5 X Residence	8 🗆 Oth	er (Specify)			
27. MANNER OF DEATN		28a. DATE OF INJUR	Y 28b.	. TIME OF	26c. INJ	URY AT		SCRIBE NOW	NJURY OCCU	RED	
	Pending	(Month, Day, Yee	7)	INJURY M		RK? 'ES 2 NO					
2 Accident 3 Suicide	Investigation	28e. PLACE OF INJU		irm, atreet, fe	ectory, office		281. LO	CATION (Street	end Number or	r Rural Rou	ite Number,
4 Nomicide	Could not be determined	building, etc. (S	(pecify)				City	or Yown, State,			
296. CERTIFIER TYTCER	TIFYING PHYSICI	AN: To the best of my kr	contactor death or	coursed at sh-	time dat-	and place and 4:	a to the c-	usals) and si	aner er met -		
ana)		On the basis of examina									and manner se stated.
		1			u			present of			
29h SICHATURE AND TITLE	CERTIFIER	y y m	1)			29c. LICENSE NU					forth, Day, Year)
	, ,		Y			D21463			Oct	ober	21, 1995
Bruce A. Sil	ver, M.	D. 2101 Me	edical P	(Type, Print) ark D	rive,	Silver	Spr	ing, Ma	arylan	d 20	902
31. DATE FILED (Month, Day,	Year)	32. REGISTRAR'S S	GNATURE								
OCT 25	1995	Julia Davelso	x Kardall,								

25-1-129

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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral directic, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation. or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

RICHARD H.

31. DATE FILED (Month, Day, Year)

OCT 25 1995

23, REGISTRAN'S SIGNATURE
Julia D'auxilian Randalle

										9	5	3363	U
	1 - FOR STATE REGISTRAR	STATE OF N	MARYLAN	D / DEPAR					MENTAL HYGIEN REG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last)								2. DATE OF DEATH	LY.	YEAR	3. TIME OF DEAT	гн
	PAULINE ALVERTO	MITCHELL	CLAR	ζ					October 22			5:15	Рм
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In y	rs. last birthday)		R 1 YEAR	IF UNDER		7. DATE OF BIRTH (Month, Day, Year)		8. BIRTI	HPLACE (State or Fo	oreign
- 11	230-01-8841	1 ☐ M 2 🂢 F	8	36 YRS.	MONTHS	DAYS	HOURS	MIN.	Aug. 17,	909		ginia	
	9a. FACILITY NAME (If not institution, give st	reet and number)			9b. CIT	Y, TOWN C	R LOCATIO				UNTY OF E		
S S	1022 Tracy Drive				Sil	lver	Spri	ng		Mor	ntgon	nerv	
5	RESIDENCE OF DECEDENT												
2	10s. STATE 10b. COUNTY					OR LOCAT						10d, INSIDE CITY LIMITS?	
	Maryland Montg	omery		Si	.lver	Spr						1 X YES 2 🗆	NO
3A	10e. STREET AND NUMBER						ZIP CODE	E		-		WHAT COUNTRY?	
	1022 Tracy Drive					20	904			Uni	Lted	States	
BY FUNERAL DIRECTOR	11, MARITAL STATUS 1 Never Married 2 Merried 3XX Widowed 4 Divorced	12. WAS DECEDEN FORCES? 1 IF YES, GIVE W	YES 2	NO		If yes, sp		n, Maxica	IIC ORIGIN? (Specify Yea n, Puerto Rican, etc.)	or No—	14. RAC Blac Spec	E — American Indick, White, etc. city: Blac	
	15. DECEDENT'S EDUC		16	a. DECEDENT'S	USUAL C	OCCUPATION	N .		166. KIND OF BUS	SINESS/IN	DUSTRY	2200.	
COMPLETED	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5	,,	(Give kind of life. Do NOT u	work done se retired.)	during mo	st of workin	g					
릴	12	2		Statist	ical	LSup	ervi	sor	Federal	L Gov	<i>j</i> ernn	nent	
ő	17. FATHER'S NAME (First, Middle, Last)						18. MOTH	IER'S NA	ME (First, Middle, Maiden	Sumame)			
BEC	James Mitchell						Kat	e El	liot				
	19a. INFORMANT'S NAME (Type/Print)			19b. MAILING	ADDRES	S (Street a	nd Number	or Rural F	Route Number, City or Tow	n, State, Z	ip Code)		
2	Morris William Cl	ark, Jr.		1022 7	racy	, Dri	ve,	Silv	er Spring	Mar	cylar	nd 20904	
1	20a, METHOD OF DISPOSITION 1X Paurial 2 Cremation 3 Remo		20b. PL	ACEANDDATE	OF DISPO	SITION (Na	me of		DATE 20c. LO	CATION -	- City or Ti	own, Stata	
	4 Donation 5 Other (Specify)	Will from State	Ar1	ry, crematory or coington	Nati	iona]	Cem	eter	y10/30 Ar	lingt	ton,	Virginia	a
	21. SIGNATURE OF FUNERAL SERVICE-LIC	SHSEE	/		22.	. NAME A	D ADDRES	SS OF FA	CILITY				
	> Tudier 1	1.910	ue_						Funeral Ho				3/03
4	23. PART I. Enter the diseases, or o	amplications the	t save ad th	o death De					shire Ave			Approxim	
	shock, or heart failure. I IMMEDIATE CAUSE (Finel disease or condition	List only one ceu	se on each	i ilne.						•		interval B Onset and	letween
ERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	Co Ro No DUE TO	OR AS A CO	DISEQUENCE O		Ter	7		Di Fea.	TC		154	RS
O	PART il. Other algnificent condition	a contributing to	deeth but	not resulting	in the u	nderlyin	COURS (niven in	Part I. 24s. WAS AN	ALITOREY	7 24	b. WERE AUTOPSY F	INDINGS
PHYSICIAN: MEDICAL	4	TONS!)						PERFOR			AWAILABLE PRIOR COMPLETION DF DEATH?	CAUSE
2	DID TOBACCO USE CONTI	RIBUTE TO CA	USE OF	DEATH Y	ES 🗆	NO [UNC	ERTAIN	V 🗆				
A	25. WAS CASE REFERRED TO MEDICAL		26.	PLACE OF DEA	TH (Check	k only one)							
Sic	EXAMINER?	HOSPITAL:	ER/Outpatie	int 3 🗆 DOA	OTHE		a 5 🗆 Ba	aldence	8 Other (Specify)				
H	27, MANNER OF DEATH	28a. DATE OF	INJURY	28b. TIR	AE OF	28c. INJ	URY AT		28d. DESCRIBE HOW	INJURY O	CCURED		
	Natural 5 Pending	(Month, E	Pay, Year)	IN	JURY		RK7	NO					
TED BY	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. PLACE (building.	OF INJURY — atc. (Specify)	At home, farm,	street, fed	ctory, offic	•		261. LOCATION (Street City or Town, State)		er or Rural	Route Number,	
COMPLETED	29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINE								to the cause(a) and ma			(a) and menner as s	stated.
	29b. SIGNATURE AND TITLE OF CERTIFIES	-						ENSE NUA					
BE	Kiliand 1)	lle	1	(2)				95	and the second s	≥ /	O /	O (Month, Day, Year)	-
임	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAU	SE OF DEATH	(ITEM 27) (Type	e Print1		ب رنــ	/-1	. /	1	012	1/71	

10400

DHMH-16 Ray 1/89

1995

1976

3 TIME OF DEATN

P

11:38

10d. INSIDE CITY

White

1 TYES 2 NO

interval Batween Onset and Daath

1 month

2½ years

AVAILABLE PRIOR TO

1 TES 2 NO

COMPLETION OF CAUSE OF DEATH?

8. BIRTHPLACE (State or Foreign

Maryland

REG. NO

2. DATE OF DEATH

7. DATE OF BIRTH (Month, Day, Year) Aug. 30,

October 20

STATE REGISTRAR

4. SOCIAL SECURITY NUMBER

213-117321

1, DECEDENT'S NAME (First, Middle, Last)

Douglas

5. SEX

1 X M 2 | F

Lynn

19

6. AGE (In yrs. lest birthday)

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permit. Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street end number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATN DIRECTOR Spencerville 16109 Asa Drive Montgomery RESIDENCE OF DECEDENT 10s. STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION Spencerville Maryland Montgomery FUNERAL 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? use as the burial-transit 16109 Asa Drive 20868 United States retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yee or Noif yee, specify Cuben, Mexican, Puerto Ricen, atc.)
 U YES 2 NO Specify: t4. RACE — American indian, Black, White, etc. 1 X Never Merried 2 Merried Specify BY 3 Widowed 4 Divorced ETED 16a. DECEDENT'S USUAL OCCUPATION 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high (Give kind of work done life. Do NOT use retired.) jo Elementary/Secondary (0-12) College (1-4 or 5+) COMPL 12 be detached Student Education Once. 17. FATNER'S NAME (First, Middle, Last) ts. MOTNER'S NAME (First, Middle, Maiden Sumeme, 76 Robert Ray Conley Elizabeth Myers 8 notified page 5 should 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 Robert & Elizabeth Conley Same as 10 within 24 hours after death. Page 6 may be pe 20a METHOD OF DISPOSITION
1 N Burlel 2 Cremetion 3 Removal from State 20c. LOCATION — City or Town, State Harrisonburg, Virginia 20b. PLACE AND DATE OF DISPOSITION (Name of DATE must director, Weaver's Cemetery 4 Donation 8 Other (Specify) 10 - 25examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSE 22. NAME AND ADDRESS OF FACILITY funeral (Rapp Funeral Services, P. A. leen 933 Gist Avenue, Silver Spring, MD 20910 filled in by the fillion, or removal. 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiretory arrest, shock, or heart feiture. List only one ceuse on each line. medical **IMMEDIATE CAUSE (Fine)** disease or condition event, the cremation, . Hepatic Failure completely reaulting in death) DUE TO (OR AS A CONSEQUENCE OF) executed burial, Malignant Peritoneal Mesothelioma traumatic CERTIFICATION and Sequentielly ilst conditions, DUE TO (OR AS A CONSEQUENCE OF): attending physician at ental Hygiene prior to if any, leading to immediate cause. Enter UNDERLYING 2 certificate other t CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 death the atten injury, PART II. Other algorificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS the MEDICAL this certificate has been signed by the with the State Dept. of Health and PERFORMED? that any 1 - YES 2 X NO Shows DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\Boxed{1}\) NO \(\overline{\overline{\text{V}}}\) UNCERTAIN \(\Boxed{1}\) PHYSICIAN: 3W 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATN (Check only one Item HOSPITAL T YES 2 X NO I ☐ Inpetient 2 ☐ ER/Outpetient 3 ☐ DOA OR ATTENDING PHYSICIAN: 4 - Nursing Nome 5 | Residence 8 - Other (Specify) 6 27. MANNER OF DEATH 28c. INJURY AT WORK? 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME DF 28d. DESCRIBE NOW INJURY OCCURED marked, XX Natural 5 Pending investigation 1 YES 2 NO DIRECTOR: After the hours after death v BY 2 Accident 3 Suicide 28e. PLACE OF INJURY -- At home, ferm, street, factory, office building, atc. (Specify) 8 Could not be determined 281. LOCATION (Street end Number or Rural Route Number, City or Town State) 69 ETED. 4 Homicide 28 Пеш 29e. CERTIFIER (Check only one)

A CERTIFYING PNYSICIAN: To the best of my knowledge, desth occurred at the time, data end piece, end due to the cause(e) and menner ee stated. COMPL FUNERAL D within 72 h HOSPITAL 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(e) and menner as stated. TO THE HOSPITA TO THE FUNERAL De filed within 72 IMPORTANT: II 29b. SIGNATURE AND THELE OF CERTIFIC 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE DOT. 21, 1995 D 36249 2 WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Seibel, M. D., 111 Michigan Avenue, NW, Washington, DC Nita 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE Savilson Rarlall 23 1995

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

Conlev

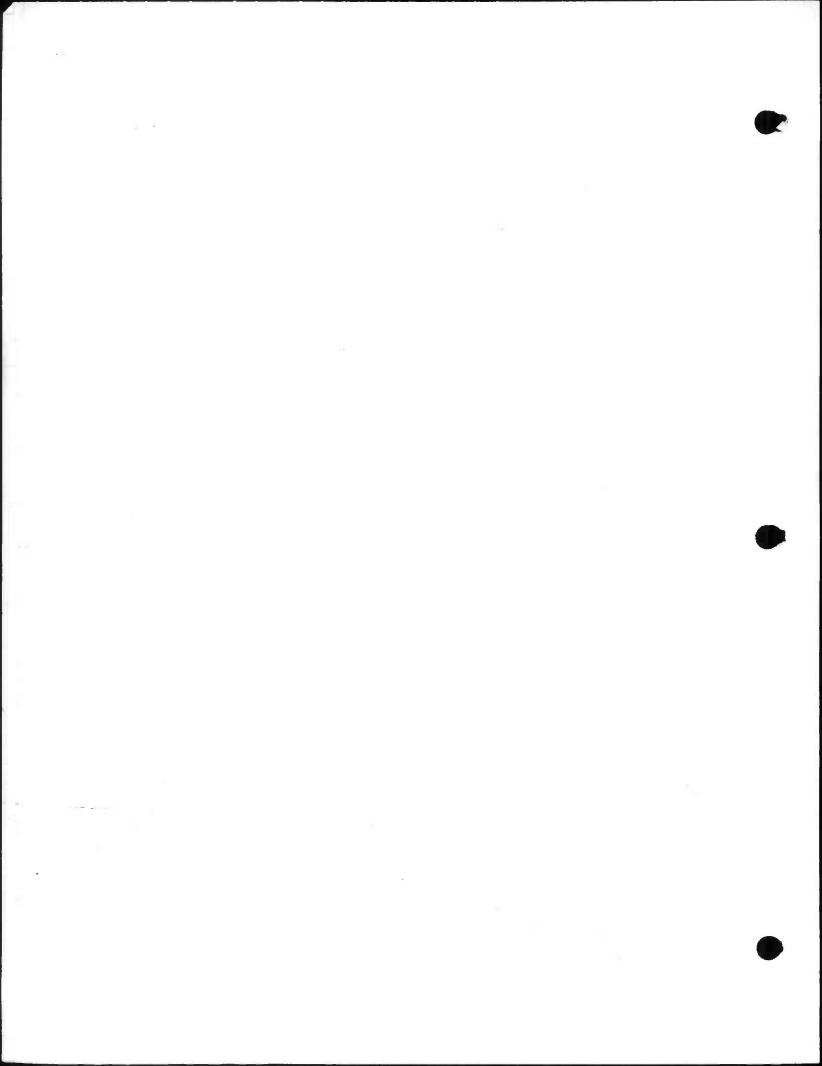
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IF UNDER 24 HRS.

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	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, Pa	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral or be fleed within 72 hours after death with the State Dent, of Heath and Mental Hydiens prior to burial commandon, or neumbal	IMPORTANT: If item 28 is marked or item 23 shows are injury or other trainingle event the medical aramine

		1 - FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPART	MENT OF H	EALTH AND W	IENTAL HYGIEN		
		1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH MONTH DA		3. TIME OF DEATH
		MARY Bagalini		ARK			OCT. 26,	1995	11:15 A M
		571-22-7055	1 □ M 2 X F 69	yrs. lest birthday) YRS.	MONTHS DAYS	HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) May 31, 1	Cou	THPLACE (State or Foreign ntry)
	OR	9a. FACILITY NAME (If not institution, give street 19123 Capehart Dr.			9b. CITY, TOWN O	R LOCATION OF DEA	тн	9c. COUNTY OF	
	DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		10c. CITY	TOWN OR LOCAT			Horroge	10d. INSIDE CITY
	1	Maryland Mont	gomery		hersbur	g			1 YES 2 X NO
	FUNERAL	19123 Capehart Dri	Ve			20879			WHAT COUNTRY?
	5	11. MARITAL STATUS 1	12. WAS DECEDENT EVER IN U		13. WAS DEC	ENDENT OF HISPANI	C ORIGIN? (Specify Yes	or No- 14. RA	States CE - American Indian,
	ВУ Е	1 Never Married 2 X Merried 3 Widowed 4 Divorced	FORCES? 1 YES			2 NO Specify:	, Puerto Rican, etc.)		ck, White, atc.
	60	15. DECEDENT'S EDUCAT	TION 1	6a. DECEDENT'S U	SUAL OCCUPATIO	N	16b. KIND OF BUS	INFEC/INDIGETOV	White
		(Specify only highest grade co. Elementary/Secondary (0-12)	college (1-4 or 8 +)		ork done during mad		IOU. KIND OF BOS	MESS/MD05 (R)	
ed	COMPL	12		Executiv	e Secre	tary	Dept. o	f Navy	
rt once.		17. FATHER'S NAME (First, Middle, Last) Thomas	Pogo1	ini			E (First, Middle, Meiden		
Hed a	BE	190. INFORMANT'S NAME (Type/Print)	Bagal	_	DDBESS /Street or	Inez	oute Number, City or Town	Rimo	rq1
be notified at	2		(Husband)	Same a		to Number of North Mc	are Number, City or low!	n, Stare, Zip Code)	
must be		20a. METHOD OF DISPOSITION 1	al from State 20b. P	LACE AND DATE OF	DISPOSITION (Na	ne of	DATE 20c. LO	CATION — City or	Town, State
er m		4 Donation 5 Other (Specify)	Ch	ery, crematory oc oth esapeake		_		tsville	, MD
examiner		2 H-B/		M00827	Rapp		Services, Silver Sp		20910
medical	П	22 PART i. Enter the disesses, or con	nplications that coused t	he deeth. Do no	900 0	ie of dying, such	as cerdiac or respi	ratory arreat,	Approximate
event, the me		ahock, or heart fellure. Lis IMMEDIATE CAUSE (Final disease or condition resulting in death)	Metasta		Breas	t Cana	er		interval Between Onset and Death 21/2 Yrs.
	CERTIFICATION	Sequentisily list conditions, if any, leading to immediate	DUE TO (OR AS A C	ONSEQUENCE OF)					
ta ta	S	CAUSE (Disesse or injury							
or oth		that initiated events resulting in death) LAST	DUE TO (OR AS A C	ONSEQUENCE OF):	:				
injury, o		DARY II. Other standing March and Miles							
	CAL	PART II. Other algnificent conditions of	contributing to deeth but	not resulting in	the underlying	ceuse given in P	PERFOR	MED?	b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE
shows a	MEDIC					-	1 TYES 2	X] NO	OF DEATH?
		DID TOBACCO USE CONTRIE	BUTE TO CAUSE OF	DEATH YES		UNCERTAIN	_		1 YES 2 A NO
Item 23	SICIAN:	25. WAS CASE REFERRED TO MEDICAL		PLACE OF DEATH	(Check only one)				
0	IX	1 TYES 2 X NO 1	☐ Inpetient 2 ☐ ER/Outpeti	ent 3 🗆 DOA		5 X Residence 8	Other (Specify)		
marked.	ВУ РНУ:	27. MANNER OF DEATH 1 X Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	28b. TIME INJUI	RY WOI		28d. DESCRIBE HOW IN	JURY OCCURED	
28 Is	ETED E	3 Suicide 8 Could not be determined	26e. PLACE OF INJURY — building, atc. (Specify)	At home, farm, atr	eat, factory, office	:	281. LOCATION (Street e. City or Town, Stete)	nd Number or Rural	Route Number,
IMPORTANT: If item	MPLE	29e. CERTIFIER (Check only 1 CERTIFYING PHYSICIA	IN: To the best of my knowled	ge, death occurred	at the time, date	and place, and due to	the cause(e) and man	ner en stated.	
NT:	COM		On the basic of examination e						(e) end manner ee stated.
ORT	BE	296. SIGNATURE AND TITLE OF OFTHER	17-66			29c. LICENSE NUMB	ER	29d. DATE SIGNE	D (Month, Day, Year)
E	2	30. NAME AND ADDRESS OF PERSON WHO C	COMPLETED CAUSE OF DEAT	MO	Print)	02277	25	P Oct.	26, 1995
		Frederick G. Barr	. M.D. 2	101 Medi		CDr #201	, Silver	Spring	MD 20902
		31. DATE FILED (Month, Day, Year) OCT 2 7 1995	32. REGISTRAR'S SIGNATI	URE Silv		#401	, Janvor	opraily,	1,5 20002
		1000							



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L. OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the death. Page 6 may be retained by the hospital or attending physician.	L OMECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	lied within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	1873 M. Ham 28 is marked or liem 23 shows any injury or other traumatic event, the medical examiner must be notified at once.
TO THE HOSP.	TO THE FUNE	be filed within	IMPORTANT

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATN 3. TIME OF DEATH 1995 Pauline Culbertson 8:25 A M October A SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, You 5 SEY 6. AGE (In yrs. last birthdey) 8. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHE DAYS HOURS MIN. 228-40-9458 1 M 2 X F 87 July 2, 1908 New York 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY. TOWN OR LOCATION OF DEATN 9c. COUNTY OF DEATH Medlantic Manor at Layhill Montgomery Silver Spring RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Montgomery Silver Spring Maryland 1 YES 2 X NO 10e. STREET AND NUMBER 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 2601 Bel-Pre Road 20906 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yee or No-14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES If yes, specify Cuban, Mexicen, Puerto Rican, etc.)

1 YES 2 NO Specify: 3 ₹ Widowed 4 □ Divorced White 16a. DECEDENT'S USUAL OCCUPATION 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade comp (Give kind of work done during life. Do NOT use retired.) College (1-4 or 5+) Elementary/Secondary (0-12) 12 Homemaker Own Home 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) Sheldon Smith Allie E. Fisk 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lenore Phillips 115 Carroll Street, N.W., Washington, D.C. 20a. METHOD OF DISPOSITION DATE 20c. LOCATION — City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of Burlel 2 X Cremation 3 - Ramoval from State Fort Lincoln Crematory 10/25 Brentwood, Maryland 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL BERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Hines-Rinaldi Funeral Home 06 11800 New Hampshire Avenue Silver Spring, Maryland 20904 23. PART I. Enter tha diseases, or complications that caused the deeth. Do not antar the mode of dying, such as cardiac or respiratory arrest, **Approximata** shock, or heart failure. List only one ceuse on each line. intarvai Between Onset and Death IMMEDIATE CAUSE (Final MINENATY EMBOLISM
DUE TO (OR AS A CONSEQUENCE OF): disease or condition 15 min ulmenery resulting in death) Immobilization month Sequentially ilst conditions, if any, leading to immediate month cause. Enter UNDERLYING CERC DED VESCULEN -CAUSE (Diseese or injury that initiated events resulting in death) LAST years lupertension PART II. Other algrificant conditions contributing to death but not resulting in the underlying ceuse given in Part i. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PERFORMED? AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 - YES 2 NO OF DEATH? TES Z NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 26. PLACE OF DEATN (Check only one) 25. WAS CASE REFERRED TO MEDICAL HOSPITAL OTHER:
4 Nursing Nome 8 Residence 8 Other (Specify) 1 TES 2 NO Inpatient 2 ER/Outpatient 3 DOA 28a. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. OESCRIBE NOW INJURY OCCURED 1 Natural 5 Pending 1 - YEO 2 NO 2 Accident Investigation 28a. PLACE OF INJURY — At home, ferm, street, factory, office building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 8 Could not be 4 Nomicide determined 1 DERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and piece, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner as stated 29d. DATE SIONED (Month, Day, Year)

> Oct. 25, 1995 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER

WNO COMPLETED CAUSE OF DEATH (ITEM 27) (Type.

32. REDISTRAR'S SIGNATURE

Belcrest

6525

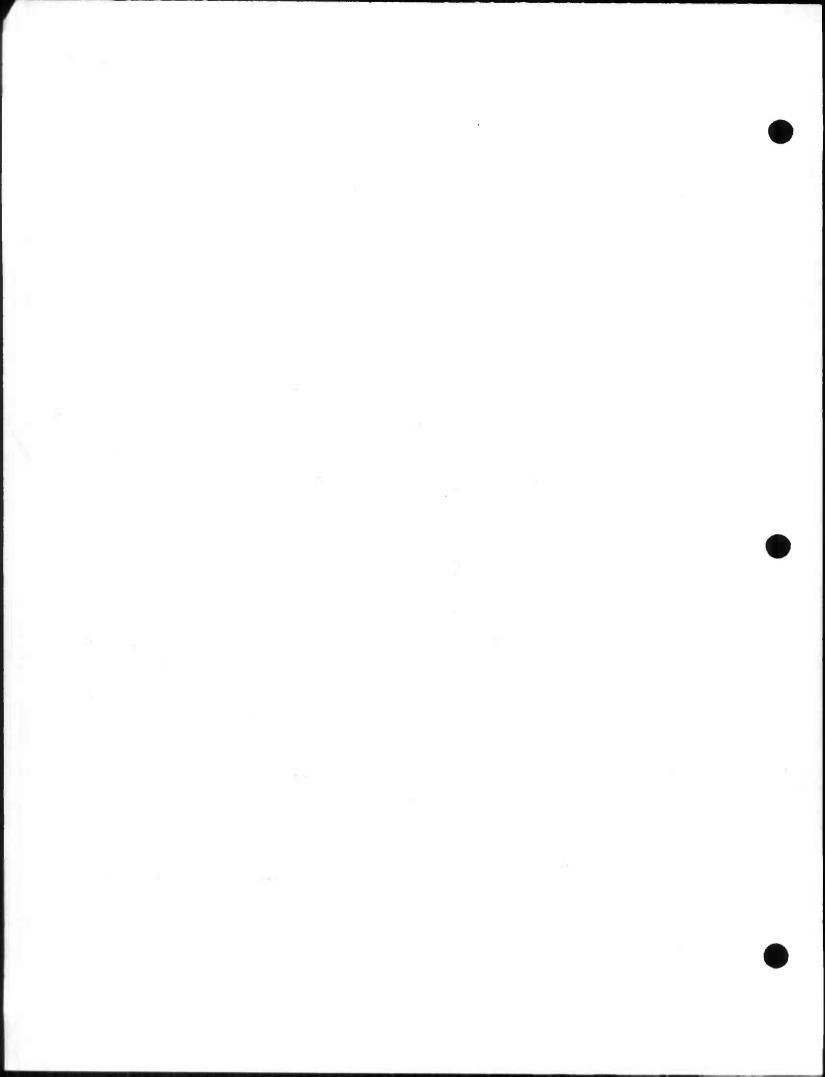
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31. DATE FILEO (Month, Day, Year)

OCT 2 7 1995

DNMN-18 Rev 1/89

Hyatsville MD 20782



1995

9c. COUNTY OF DEATH

3. TIME OF DEATH

8. BIRTHPLACE (State or Foreign Country)

Montgomery

10g. CITIZEN OF WHAT COUNTRY?

United States

Specify:

14. RACE — American Indian, Black, White, atc.

Minnesota

10d. INSIDE CITY LIMITS? 1 YES 2 X NO

White

Wisconsin 3501

Approximate

24b. WERE AUTOPSY FINDINGS

1 YES 2 NO

AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?

Interval Between

Onaet and Death

10:45 P M

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DIVISION OF VITAL RECORDS, P.O. BOX 68760. TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or re-	IMPORTANT: It Item 28 is marked, or Item 23 shows any injury, or other traumalic event, the med
F VITAL RECORDS, P.O. BOX 68760. SICIAN: The law requires that the death cardificate be executed with certificate has been signed by the attending physician and complete the State Dept. of Health and Mental Hygiene prior to burial, crem.	shows any injury, or other traumatic event,
F VITAL RECORDS, P.O. BOX 687 SICIAN: The law requires that the death certificate be executed certificate has been signed by the attending physician and con the State Dept. of Health and Mental Hygiene prior to burial.	shows any injury, or other traumatic of
F VITAL RECORDS, P.O. BOX SICIAN: The law requires that the death certificate be ex- certificate has been signed by the attending physician a the State Dept. of Health and Mental Hygiene prior to	shows any injury, or other traum
F VITAL RECORDS, P.O. Bi SICIAN: The law requires that the death certificate certificate has been signed by the attending phys the State Dept. of Health and Mental Hygiene pr	shows any injury, or other i
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F VITAL RECORDS, F SICIAN: The law requires that the deatl certificate has been signed by the atte the State Dept. of Health and Mental	shows any injury,
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - STATE REGISTRAR CERTIFICATE OF DEATH REG. NO. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH October 24, Ruth Clark 7. DATE OF BIRTH (Month, Day, Year) 4. SOCIAL SECURITY NUMBER 5 SEY 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. 1 - M 2 X F YRS. 578-84-2982 99 Oct. 6, 1896 PACILITY NAME (If not institution, give street and number)
FOX Chase 96 CITY TOWN OR LOCATION OF DEATH Rehabilitation & Nursing Center Silver Spring RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION Maryland Montgomery Bethesda 101. ZIP CODE 5507 Burling Court 20817 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 XNO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-11. MARITAL STATUS FORCES? 1 YES 2
IF YES, OIVE WAR OR DATES If yes, specify Cuban, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify: 1 Never Married 2 Married 3 🕅 Widowed 4 🗌 Divorced 16a. DECEDENT'S USUAL OCCUPATION
(Qive kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade comple Elementary/Secondary (0-12) College (1-4 or 5+) 4 Homemaker Own Home 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Edmund Berrigan Johanna Morrissey 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADORESS (Street and Number or Rural Route Number, City or Town, State, Zio Code) Edmund B. Clark 5507 Burling Court, Bethesda, Maryland 20817 20s. METHOD OF DISPOSITION
1 □ Burtal 2 X Cremation 3 □ Removal from State
4 □ Donation 8 □ Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of cemetary, cremetory or other place) Oct. 26, 1995 Montgomery Crematorium, Inc. 20c. LOCATION -- City or Town, State Bethesda, Maryland 22. NAME AND ADDRESS OF FACILITY ROBERT A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Avenue, Bethesda, Maryland 20814-21. SIGNATURE OF FUNERAL SESSOCI LICEN M@0831 Darbara Kauhen 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, ahock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition ovascu resulting in deeth) DUE TO (OR AS A CONSEQUENCE OF) Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST

DID TOBACCO USE CONT	RIBUTE TO CAUSE OF DEATH	YES NO	UNCERTAIN 5
25. WAS CASE REFERRED TO MEDICAL	26. PLACE OF C	DEATH (Check only one)	
EXAMINER? 1 YES 2 X NO	HOSPITAL: 1 Inpetiant 2 ER/Outpetient 3 DO	A 4 X Nursing Home	5 Residence 8

PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I.

a)

4 X Nun 8 Other (Specify) 28d. DESCRIBE HOW INJURY OCCURED

28c. INJURY AT WORK?

1 YES 2 NO 28b, TIME OF INJURY 28a. DATE OF INJURY 28s. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify)

29e. CERTIFIER (Check only one)

2 MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as atteted.

281. LOCATION (Street and Number or Rural Route Number, City or Town, State)

24a. WAS AN AUTOPSY PERFORMED?

1 - YES 2 X NO

29b. SIGNATURE AND TITLE	OF CERTIFIER		
1			
-			5
AS MANE AND EDDDESS OF	PERSON WINO COMP	ETER CAUSE OF DEAT	A STEM OF ST.

29c. LICENSE NUMBER

October 26, 1995

29d. DATE SIGNED (Month Day Year)

DChun MD 2309 Shorefield

						-
31.	DATE FI	LED (Month,	Day.	Year)	
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27. MANNER OF DEATH

5 Pending

8 Could not be

determined

1 X Natural

2 Accident
3 Suicide

4 Homicide

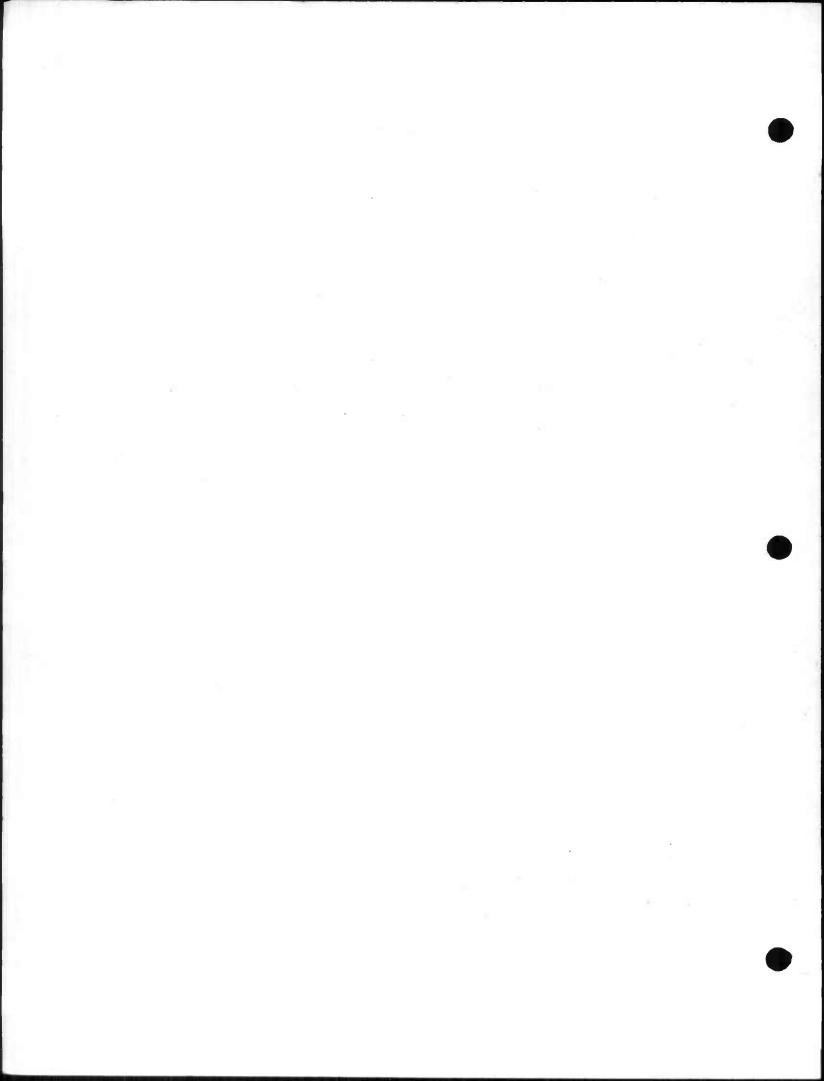
32. REGISTAAR'S SIGNATURE

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed wittin 24 hours after death. Page 6 may be retained by the hospital or attending physician.	DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	and Merital Hygiehe pnor to bunal, cremation, or removal.	sd, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in	be filed within 72 hours after death with the State Dept. of Health and Mental Hygliehe prior to bunal, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the med

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

	1 - FOR STATE REGISTRAR	STATE OF MARYL			HEALTH AND I		HYGIENI REG. NO.	E		
- 8	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF	DEATN			3. TIME OF DEATN
	MARK A	DIP	IETRO,	JR.		OCTO		25.1	YEAR	0102 A M
	A CONTRACTOR OF THE PROPERTY O		(In yrs. last birthday)	IF UNDER 1 YEAR	7	7 DATE OF	BIRTH			PLACE (State or Foreign
- 1	219-92-5597	X M 2 F	17 YRS.	MONTHS DAYS	HOURS MIN.	May	18 1	978	Ma	ryland
	9e. FACILITY NAME (If not institution, give street	of end number)		9b. CITY, TOWN	OR LOCATION OF DE	EATH		9c. COUN	TY OF D	EATH
DIRECTOR	UNIVERSITY HOSP	'ITAL		BALTI	MORE CIT	ГУ				
RE	100. STATE 10b. COUNTY	. 1 1		Y, TOWN OR LOC						10d. INSIDE CITY LIMITS? V
	Maryland Carro	11	F.	nksbu	.5					1 YES 2 NO
FUNERAL	10e. STREET AND NUMBER	0 - 3			10f. ZIP CODE					HAT COUNTRY?
NEI	2011 Sandymount				21048					States
ВУ	11. MARITAL STATUS 1 X Never Merried 2 Merried 3 Widowed 4 Divorced	2. WAS DECEDENT EVER II FORCES? 1 YES IF YES, GIVE WAR OR D	2 XNO	II yes,	ECENDENT OF HISPAI specify Cuben, Mexica ES 2 M NO Specif	an, Puerto Ric		or No-	Black	- American Indian, White, etc. White
ED	15. DECEDENT'S EDUCAT		16s. DECEDENT'S	USUAL OCCUPA	TION	16b. K	IND OF BUS	INESS/IND	USTRY	
COMPLETED	(Specify only highest grade co	College (1-4 or 5+)	life. Do NOT us	work done during : se retired.)	most of working					
AP.	11		superv	risor		C	ar w	ash	fac	ility
Ö	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	AME (First, Mid	ldle, Meiden	Surneme)		
BE (Mark Anthony Di	Pietro S	r.		Marth	na El	izab	eth	Gee	r
0	19a. INFORMANT'S NAME (Type/Print)				et end Number or Rural					
-	M. Elizabeth Di				_			sbur	g,	MD 21048
	20a, METHOD OF DISPOSITION 1 X Burlei 2 Cremetion 3 Removi	al trom State Cer	netery, cremetory or o	OF DISPOSITION	NeTe0/28/9	95 DATE	20c. LO	CATION — C	City or To	wn, State
	4 Donation 8 Other (Specify)				h Cemete			dies	bur	a, MD
	21. SIGNATURE OF FUNERAL SERVICE LICEN	JSEE		22. NAME Pr	itts Fur	icility neral	Hom	2 &	Cha	nel
	Katrerini Pu	Ho - Sweet	ur							inster,MD
ATION	23. PART I. Enter the diseases, of conscious ahock, or heart fallure. List IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	GUNSHOT WOUN DUE TO (OR AS A	esch line.	F):						Approximate interval Between Oneat and Daath
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST b. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):						·				
PHYSICIAN: MEDICAL	PART II. Other significent conditions						4a. WAS AN PERFOR	MED?	24b.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 NO
ż	DID TOBACCO USE CONTRI	BUTE TO CAUSE C				N 🗆				
C	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEA	TH (Check only or OTHER:	10)					
YSI	1 XYES 2 NO	□ Inpatient 2 XER/Out		4 Nursing H	ome 5 Residence		77			
F	27. MANNER OF DEATH 1 Natural 5 Pending	28s. DATE OF INJURY (Month, Day, Year)		JURY	INJURY AT WORK?		RIBE HOW II	NJURY OCC	URED	
ВУ	2 Accident Investigation	Investigation 10-25-95 UNKNOWN to the AAC NO UNKNOWN								
COMPLETED	3 Suicide 8 X Could not be determined	building, etc. (Spe	r — At nome, term,		TICS	FINKSB	Town, Stele)	2100 B	BLK. I	VOODVIEW RD.
PLI	290. CERTIFIER 1 CERTIFYING PHYSICIA	AN: To the best of my know	vledge, death occurr	ed at the time, d	ate end place, end due	e to the cause	e(s) end mer	ner es atate	ed.	
O	2 MEDICAL EXAMINER:	On the beels of exemination	on end/or investigation	on, in my opinion	, death occured at the	e time, date e	nd plece, an	d due to the	e cause(a) and manner as atated,
	TO DIGNATURE AND TITLE OF CENTIFIER	1 . 1			29c. LICENSE NU	мвен		29d, DATE	HIGNED	(Month, Day, Year)
) BE	Allorton	re me)		O.C.M	. E.		Poc	TOB	ER 25.1995
5	30 NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DE			t. Balti	4-60-4	Mes			
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGN	NATURE		- uall	THUT P	, P.	YIA	10	(1/01
	OCT 2 7 1995	Jalin Davide	or Revoll							



BALTIMORE, MARYLAND 21215-0020

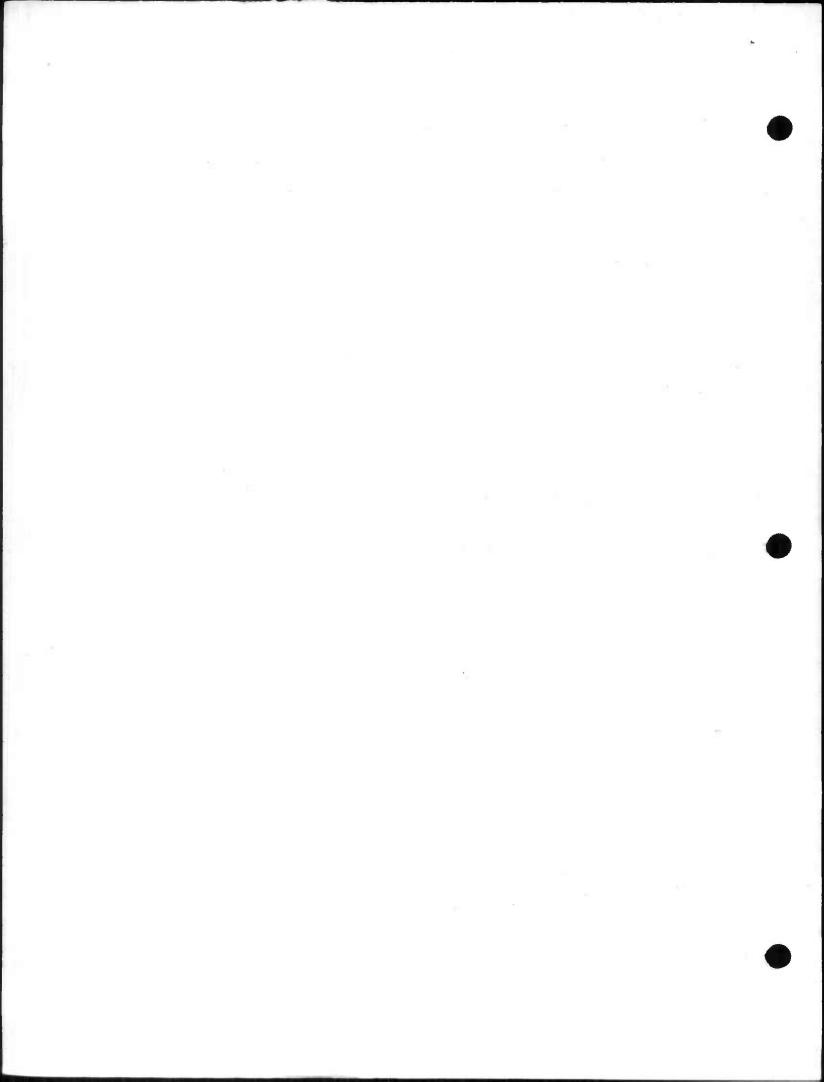
DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNEAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the hunditraneir nermin Panes 1 2 security
be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once,

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH
REG NO

					ICATE	01	ואכו	111	REG. NO.	_		
	1. DECEDENT'S NAME (First, Middle, Last)	_		1					2. DATE OF DEATH DA		YEAR	3. TIME OF DEATH
	Ruth	I).	D	onau	Jac	4		october 1		196	17.30 M
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. las	st birthday)	IF UNDER 1 Y	EAR	IF UNDER 2		7. DATE OF BIRTH	7,1		HPLACE (State or Foreign
	222-16-5220	1 - M 2-F	M 2XXF 68 YRS. MONTHS DAYS HOURS MIN. (Month, Dey, Year)						۵ ا	Count	ry)	
10	9e. FACILITY NAME (If not institution, give str		- 00									aware
œ					96. CITY, TO				тн	9c. COUI	NTY OF D	HTAS
ō	PENINSULA REGIO	NAL MEDI	CAL CEN	TER		SA	ALISB	URY		W)	COM:	ICO
2	RESIDENCE OF DECEDENT 100. STATE 100. COUNTY											
DIRECTOR				10c. CIT	Y, TOWN OR	LOCATIO	ON					10d. INSIDE CITY LIMITS?
	Delaware Sussex			Mil.	lsbord)						1 YES 2XXNO
AL	10e. STREET AND NUMBER					101.	ZIP CODE			10g. CITI	ZEN OF V	WHAT COUNTRY?
8	299 W. State Stre	et					1996	6			TC A	
FUNERAL		12. WAS DECEDENT	EVER IN ILE AD	4450	40. 110			_			JSA	
ᄄ	1 Never Married 2 🔣 Married	FORCES? 1	YES 2	NO	is. vec	es, spec	city Cuben,	Mexican,	C ORIGIN? (Specify Yee Puerto Rican, etc.)	or No-	14. RACE Black	E — American Indian, k, White, etc.
BY	3 Widowed 4 Divorced	IF YES, GIVE W	AR OR DATES		1 [YES :	NO	Specify:			Speci	Hy:
	15, DECEDENT'S EDUCA	-						-		1		White
쁘	(Specify only highest grade c	ompleted)	(G	ive kind of s	USUAL OCCU	IPATION ing most	t of working		16b. KIND OF BUS	INESS/ING	USTRY	
	Elementary/Secondary (0-12)	College (1-4 or 5+		. Do NOT us	se retired.)							
9	12		hom	emak	er							
COMPLETED	17. FATHER'S NAME (First, Middle, Lest)						16. MOTHE	R'S NAM	E (First, Middle, Maiden	Sumame)		
ш	Francis Donaway								Davis			
00	19e. INFORMANT'S NAME (Type/Print)		19	b. MAILING	ADDRESS /S	treet en			ute Number, City or Town	Ctata Zin	Code	
2	John R. Donaway											10066
	20e. METHOD OF DISPOSITION							Mill	sboro, De			
	1 Buriel 2 Eremetion 3 Remove	at from State	cemetery, cre		OF DISPOSITION	ON (Nam	ne of		DATE 20c. LOC			
	4 Donation 5 Other (Specify)		Capit	01 C	remato	ry	Ser.		10/17 Dov	er, I	De la	ware
- 1	21. SIGNATURE OF FUNERAL SERVICE LICE	NSEE	1		22. NA	ME ANO	ADDRESS	OF FACI	LITY			
	Draft IT	- //	+		Wats	son	Fune	ral	Home, Mil	1shor	ro . 1	Del. 19966
-	Theres !	wa	Leor								-	DC1. 17700
	23. PART I. Entar the diseases, or co shock, or heart failure. Li	mplications that ist only one caus	caused tha da se on each line	ath. Do n	ot antar th	a mod	a of dyln	g, such	as cardiac or reapli	retory arr	eat,	Approximats
	IMMEDIATE CAUSE (Final								•			Interval Between Onset and Death
	disease or condition	ilmhi	who di	lorith	الم نام		7.	01	in regard	1	1 .7	24
	resulting in death) s.	DUE TO (OR AS A CONSE	DUENCE OF	n:	V-	4	a m	in taken	000	Jan	30
_		DUE TO			OI.	26		C 100	18 114	d	X	1 24.
CERTIFICATION	Sequantisity list conditions, b.	THE TO	OR AS A PONES	LIENCE OF	- 4	CN	rpe	Or	Juni 12	~~	1-	N 2100
A	If any, lesding to immediata csuse. Enter UNDERLYING	7	7 7 C	O SOME	<i>y.</i>	4.3			0		0	1.
일	CAUSE (Disease or Injury C.	Dink	OR AS A CONSEC	V()	MA	In lost	X					44-5
Ë	that initiated events resulting in death) LAST	DUE TO (OH AS A CONSEC	DUENCE OF	n: O 1		9					
H	d.											
	PART II. Other significant conditions	contribution to	death hist not a	a audėlaia. I	n the costs	1.1		-11114				
EDICAL	TAME SIGNIFICANT CONDITIONS	The state of the s	path but not r	aauiting i	n tha unda	rlying	cause giv	van In Pa	art I. 24a. WAS AN / PERFORE		24b.	WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO
8	- Chrise will	1 0	~ 0	dl ~					1 YES 2	NO NO		COMPLETION OF CAUSE OF DEATH?
												1 YES 2 NO
× :	DID TOBACCO USE CONTRI	BUTE TO CAL	ISE OF DEA	TH VE	SIN		UNCE	DTAIN				. L tes Z L NO
¥	25. WAS CASE REFERRED TO MEDICAL	-SIE IO CA			H (Check only		DINCE	KIMIN				
고 I	EXAMINER?	HOSPITAL:			OTHER:	Jird)						
YS		Inpatient 2		□ DOA		Home	5 🗆 Resi	dence 8	Other (Specify)			
PHYSICIAN:	27. MANNER OF DEATH 1 Natural S Panding	28s. DATE OF I (Month, Day		28b, TIMI	E OF 28- URY	c. INJUI	RY AT	1	88d. DESCRIBE HOW IN	JURY OCC	URED	
>	1 Natural 5 Pending 2 Accident Investigation						S 2 🗌	NO				
8	3 Suicide 6 Could not be	28e. PLACE OF	INJURY At ho	me, ferm, s	treet, fectory,	office		- 1	281. LOCATION (Street or	nd Number	or Rural R	loute Number.
E I	4 Homicide determined	building, s	tc. (Specify)						City or Town, State)			
Ш	290. CERTIFIER										_	
<u>a</u>	(Check only											
COMPLETED	2 MEOICAL EXAMINER:	On the basis of exa	amination end/or i	nvestigation	n, in my opini	lon, des	th occured	et the tir	me, date end place, end	due to the	ceuse(s)) end manner ee stated.
<u></u>	29b. SIGNATURE AND TITLE OF CERTIFIER		1			1	29c. LICEN	SE NUMB	ER	29d. DATE	SIGNED	(Month Cay Vent)
0	-1	2.	die	~	~ .		DI	51	92	▶ 11	1 /13	(Month, Day, Year)
2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CANO	OF DEATH OF	1070 07	Orders		VI	J 1	1	- 11	دا ا	
						٦.	,		4 7	010	0.4	
	Joseph Z. Badros			nore	Dr. S	ali:	sbury	y, 1	Maryland	218	01	
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR	'S SIGNATURE									
	DCT 16 1995	Julia di	andrag Ra	Nell								
		-										

	FOR 1 - STATE REGISTRAR	STATE OF MARYLA		TMENT OF H		MENTAL HYGIEN		
	1. OECEOENT'S NAME (First, Middle, Lest)	a C C						3. TIME OF DEATH
ľ	LOUISE SHR	IUER	Dove	ILASS		OCTOBER D	19 1995	0600 AM
			n yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIR Cou	THPLACE (State or Foreign ntry)
į	220-32-5167 9a. FACILITY NAME (# not institution, give stree	167 Feb. 13, 1905 Massachusetts						
DIRECTOR	Shady Grove Hospi	ital		Gaithe			Montgon	
EG	HESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY							
DIR	Maryland Montg	omerv	Ва	rnesvill	e			LIMITS?
	10e. STREET AND NUMBER		1 20		ZIP CODE		10g. CITIZEN OF	WHAT COUNTRY?
FUNERAL	17411 Conoy Road	i			20838		U.S.	Α.
5	11. MARITAL STATUS 1 1 Never Married 2 Married	2. WAS DECEDENT EVER IN FORCES? 1 YES				IC ORIGIN? (Specify Yes		CE — American Indian,
ВУ	3 Widowed 4 Divorced	IF YES, GIVE WAR OR DA			2 X NO Specify:			White
- 1	15. DECEDENT'S EDUCAT		16a. OECEDENT'S	USUAL OCCUPATION	ON .	16b. KIND OF BU	SINESS/INDUSTRY	
ETE	(Specify only highest grade co. Elementary/Secondary (0-12)	mpleted) College (1-4 or 5+)	(Give kind of life. Do NOT u	work done during mo se retired.)	st of working			
COMPLETED		yrs.	practi	ioner		Christi	an Scien	ce Church
00	17. FATHER'S NAME (First, Middle, Last)					ME (First, Middle, Maiden	Surneme)	
BE	Charles Frederic	ck Shriver				,	Danforth	n
2	190. INFORMANT'S NAME (Type/Print) William C. Redfern					noute Number, City or Tow		
	20a. METHOD OF DISPOSITION	200		OF DISPOSITION (No		DATE 20c. LO		Town Cast
	1 Buriel 2 Cremation 3 Remova	il trom State	etery, cremetory or o	ther place)	matory Oc	t.19,95 A1	ex. Vi	rginia
	21. SIGNATURE OF FUNERAL SERVICE LICEN	ISEE OOO		22. NAME AI	D ADDRESS OF FAC	DeVol F	uneral 1	lome
1	Demin El	30/6/						, D.C.20007
	23. PART L'Enter the diseases, or con	mplications that caused	tha daath. Do	not entar tha mo	da of dying, auch	n as cardiac or reap	iratory arreat,	Approximata
i	ahock, or heart failure. List iMMEDIATE CAUSE (Fine)	at only one ceuse on ee	ch line.					Interval Between Onset and Death
	diseese or condition resulting in death)	MYOC	ARD 11	12 INI	FARCT	102		5 mys
		DUE TO (OR AS A	CONSEQUENCE O	F):				
NO	Sequentially list conditions, b.	DUE TO (OR AS A	CONSEQUENCE O	(B)				
Ä	if any, leading to immediate cause. Enter UNDERLYING	300 10 (011 NO X	0011020021102	· j.				
E	CAUSE (Disease or injury thet initiated events	DUE TO (OR AS A	CONSEQUENCE C	F):				
CERTIFICATION	resulting in death) LAST							
	PART il. Other aignificent conditions	contributing to deeth br	ut not resulting	in the underlyin	g ceuse given in I	Part i. 24a. WAS AN	AUTOPSY 2	4b. WERE AUTOPSY FINDINGS
ICAL	MZHEIME	re's DEA	MENTI	A		PERFOI	RMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE
AED						1 10 160		OF DEATH?
PHYSICIAN: MEDIC	DID TOBACCO USE CONTRI	BUTE TO CAUSE OF	F DEATH Y	ES NO [UNCERTAIN	18		
SIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEA	TH (Check only one)				
YSI	1 - YES 2 NO 1	HOSPITAL: Inpetient 2 ER/Outpu	ntlent 3 🗆 DOA	OTHER: 4 Nursing Hore	e 5 🗆 Rasidenca	8 Other (Specify)		
	27. MANNER OF OEATH 1 Natural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b. TII		PRK?	28d. DESCRIBE HOW	INJURY OCCURED	
BY	2 Accident Investigation 3 Suicide 8 Could not be	28e. PLACE OF INJURY	— At home, term,			28t. LOCATION (Street		il Route Number,
TED	4 Homicide datarmined	building, atc. (Speci	ny)			City or Town, State,)	
PLE	29e. CERTIFIER 1 CERTIFYING PHYSICIA	AN: To the best of my knowle	edge, death occur	red at the time, date	end place, end dua	to the cause(e) end ma	nner as stated.	
COMPLET	one) 2 MEDICAL EXAMINER:	On the basis of examination	and/or investigati	on, in my opinion, o	leath occured at the	time, data and place, ar	nd due to the cause	e(s) and menner as stated.
BE C	29b. SIGNATURE AND TITLE OF CERTIFIER	chirs-	MiD		29c. LICENSE NUM	18ER 730		ED (Month, Day, Year) 119-95
5	30. NAME AND ADDRESS OF PERSON WHO O	COMPLETED CAUSE OF DEA	ATH (ITEM 27) (Type	a, Print)				
	M DATE SHED WARE SO THE			TITE DE	(ICICICIO)	7 701 10 2	10 MARI	1 (MM) 20877
	31. DATE FILED (MOREL DON 1995)	32 MEGISTRAR'S SIGNA	Rardall					
		-						



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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buriar-trained narmit. Panes 1.2.3 should
be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEDENT'S NAME (First	, Middle, Last)								2. DATE OF				3. TIME OF DEATH
	Alma		Dril	1						Octob	er 20	, 19	95	11:55 рм
	4. SOCIAL SECURITY NUME	BER	5. SEX	6. AGE (In yrs. is	st birthday)		R 1 YEAR	IF UNDER		7. DATE OF (Month, E	BIRTH			IPLACE (State or Foreign
1	119-24-34		1 🗆 M 2 😾 F	64	YRS.	MONTHS	DAYS	HOURS	MIN.	May 1	9, 19	31		York
_	9e. FACILITY NAME (If not in	stitution, give s	street and number)			9b. CIT	bb. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH					EATN		
DIRECTOR	11410 Strand Drive, #209					Nor	th B	ethe	sda		<u> </u>	Мо	ntgo	mery
l m	10a. STATE 10b. COUNTY					ry, town	OR LOCAT	TION						10d. INSIDE CITY
	Maryland Montgomery					Nor	th B	Sethe	sda					LIMITS?
FUNERAL	10e. STREET AND NUMBER		101. ZIP CODE 10g. CITIZEN OF							WHAT COUNTRY?				
ÿ	11410 Stran	d Driv							852				ted	States
	11. MARITAL STATUS 1 Never Married 2 📉	Merried	12. WAS OECEDEN FORCES? 1	YES 2 X		13.	If yes, sp	ecity_Cuba	F HISPAT n, Maxica	NIC ORIGIN? (in, Puerto Ric	Specify Yes en, atc.)	or No—	14. RACI Black	E — American Indian, k, White, atc.
ВУ	3 Widowed 4 Divo		IF YES, GIVE Y	MAR OR DATES			1 TYES	2 ₩ NO	Specify	y:			Speci	"y: white
	15. DEC (Specify only	EDENT'S EDU y highest grade	CATION completed)	16e, D	ECEDENT'S	USUAL C	CCUPATIO	ON est of workin	ng .	16b, K	ND OF BU	SINESS/INC	DUSTRY	
COMPLETED	Elementary/Secondary (0)-12	College (1-4 or 5	+1	n. Do NOT u	se retired.)				**				
1 2	17. FATHER'S NAME (First, M		4	Adve	ertis	ing	Exec	_			chum		rtis	ing
_	William Lip							111		ME (First, Mid. Schwa		Sumame)		
8	19a. INFORMANT'S NAME (10	IN MAIL IN	ADDRES	C /Ctmat o			Route Number,			0.41	~
유	Robin Campb	ell												nd 20814
	20a. METHOD OF DISPOSIT 1 Burlal 2 X Crematic 4 Donation 5 Other	on 3 🗆 Rem	oval from State	20b. PLACE cemetery, cr	ematory or o	other place	1		237	1	20c. LO		*	
	4 Donation 5 Other (Specify) Mount Comfort Crematory 10-24 Alexandria, 21. SIGNATURE OF FUNERAL SERVICE LICENSET 22. NAME AND ADDRESS OF FACILITY Joseph Gawler's								Sons Inc					
	· for	11	No	M009	956	[51	30 W	isco	nsin	Aveni	ue, N	I.W.		bond, Inc.
	23. PART I Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, Approximate													
	IMMEDIATE CAUSE (Fir													Interval Between Onset and Death
	disease or condition	\rightarrow	PANCKEA	ATIC CAN	CER									10 MONTHS
	DUE TO (OR AS A CONSEQUENCE OF):													
CERTIFICATION	Sequentially list conditions, If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):													
S	cause. Enter UNDERLY! CAUSE (Disease or Inju	ING	С.											
F	that initiated events resulting in death) LAS		DUE TO	(OR AS A CONSE	OUENCE O	F):								
빙			d											
	PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 24s. WAS AN AUTOPSY FINDINGS PERFORMED? AMILABLE PRIOR TO													
EDICAL										1	YES 2			AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
ME											•			1 TYES 2 NO
ä	DID TOBACCO U		RIBUTE TO CA	USE OF DEA	TH Y	ES 🗆	NO [UNC	ERTAIN	1 EK				
PHYSICIAN:	25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 NO	O MEDICAL	HOSPITAL;		CE OF DEA	OTHE	R:							
14S	1 YES 2 1 NO		1 Inpatient 2		_	4 🗆 Nu	sing Nom		sidence	6 Other (S				
	1 Natural 5	Pending	28a. DATE OF (Month, D		28b. TIM	JURY M		ORY AT PIK? (ES 2	I NO	28d. DESCR	IBE NOW II	NJURY OC	CURED	
ВУ	2 Decident	Investigation Could not be	28e. PLACE O	F INJURY — At he	ome, farm,	street, fac			, 110	281, LOCATI	ON (Street a	nd Number	or Rural F	Toute Number,
COMPLETED		detarmined	building,	atc. (Specify)							lown, State)			
IPL			CIAN: To the best of											
CON			R: On the besia of a	xamination and/or	Investigatio	on, in my o	opinion, d	eath occun	ed at the	time, data an	d place, and	d due lo th	e cause(a	and manner as stated.
8	296. SIGNATURE AND TITLE	10.	Rino					29c. LICE			7	29d. DAT	E SIGNED	(Month, Day, Year)
욘	30. NAME AND ADDRESS OF			SE OF DEATN (ITE	M 27) (Type	, Print)			11	757			0/2	-3/73
	DR. M.A	HAU	Kins 39	800 Rese	001K	Rd. 0	.w. L	UAShen	zlan	Dc. a	20007			
	31. DATE FILED (Month, Day,	Year)	Julia a hurd	R'S SIGNATURE	,									
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FOR STATE REGISTRAR

n 24 hours after death. Page 6 may b	pag
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DSPITAL OR ATTENDING PHYSICIAN: Th	- Service
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ġ.		1. DECEDENT'S NAME (First,	Middle, Last)	M. Da	vis						7.7.1	22	95	3. TIME OF DEATH
		4. SOCIAL SECURITY NUME	ER	5. SEX	-	s. last birthday)	IF UNDER	t YEAR	IF UNDER	R 24 HRS.	7. DATE OF BIRTH	27		PLACE (State or Foreign
		217-36-98	15	1 □ M 2 🔯 F	88	YRS.	MONTHS	DAY8	HOURS	MIN.	(Month, Day, Year) Apr. 27,	1907	Country	
phods		9a. FACILITY NAME (If not in		treet and number)			9b, CITY	, TOWN	OR LOCATI	ION OF DE			NTY OF DE	. 10
(C)	ا ۾ ا	Shady Grov	re Adv	ventist	Hosp	ital	Ro	ock.	vill	e		MO	NTGO	MERY
1. 2,	- DIRECTOR	RESIDENCE OF DEC	10b. COUNTY											
Pages		10a. STATE	10c. Cl	TY, TOWN							tod. INSIDE CITY LIMITS?			
permit. P		Maryland		ROO		ille					1 XYES 2 NO			
t per	RAL	100. STREET AND NUMBER 101. ZIP CODE 201 Ashley Avenue 20850											U.S.	HAT COUNTRY?
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ohysic xurial-		1 Never Married 2	Married	FORCES? 1	YES 2	≥ X NO		if yes, s	pecify Cubi	en, Mexicen	IC ORIGIN? (Specify Year, Puerto Rican, etc.)	s or No	Black,	- American Indian, White, etc.
fing the t	B	3 Widowed 4 Divo	rced	IF YES, GIVE Y	MAR OR DATES	s		I YE	s 2 🖂 XNO	Specify			Specif	Black
r attend use as	8		EDENT'S EDU		16	e. DECEDENT	S USUAL O	CCUPATI	ION	ina	16b. KIND OF BU	JSINESS/IN	DUSTRY	
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should 5 should notified	임	19a. INFORMANT'S NAME (7		/ ** 1	31						loute Number, City or Too Rockvill			0850
ay be page :		Edwin T. I	ION		_	ACE AND DATE				: , 1		DCATION -		
director, p		N Burial 2 Crematic	n 3 🗆 flem	oval from State						tors				Le, MD
Page I dire		21. SIGNADORE OF FUNERA		жизгу)	A 111	Incom	22.	NAME A	ND ADDRE	SS OF FAC	CILITY			
death. Pag funeral dii examiner		191N	10	Vt	MI	not 0	21				NERAL HO	ME,	P.A.	•
s after do by the f emoval.		100	110	10.10	· · ·	wire				LE,				
5 .5 . 0		23. PART I. Enter the d shock, or h	serses, or c sert fallura.	complications the List only one car	et caused th uaa on each	e deeth. Do Ilna.	not enter	the m	ode of dy	/ing, such	n as cardisc or resp	piratory sr	reat,	Approximats interval Batwee
Pen Pen		IMMEDIATE CAUSE (Fir disease or condition	ial	C_{i}	chort	Fool	Pul.	h	En	Lali	71			Onset and Deat
completely ial. cremati		disease or condition a. Justical de Tulm, Embolus a. Justical de Tulm, Embolus Des To de As A consequience del										1 11		
executed within and completely to burial, cremat matic event,	-	IMMEDIATE CAUSE (Final disease or condition resulting in death) a. US/RECTED V/M. EMBO/US DOWN TO (OR AS A CONSEQUENCE OF): HYDROUS CLERANC CONDITIONS b. HYDROUS CLERANC CONDITIONS D. Sequentially list conditions										10 Ckar		
execu n and to bur	ERTIFICATION	Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):										1		
physician ne prior to	8	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury												
ertificand no phogiene giene	띹	that initiated events resulting in death) LAS		DUE TO	(OR AS A CO	INSEQUENCE (OF):							
ath c trendi	#	resulting in death) EAS		d			-							
the a the a Men	LC	PART II. Other significa	nt condition	a contributing to	daath but i	not reaulting	In the u	ndariyir	ng cause	given in i			24b.	WERE AUTOPSY FINDINGS
that the by h and h and i	EDICAL										PERFO	RMED?		AMAILABLE PRIOR TO COMPLETION DF CAUSE
signe Signe Healt	월										_ '	1		OF DEATH?
w red been bt. of 3 she	N. M	DID TOBACCO U	SE CONT	RIBUTE TO CA	AUSE OF I	DEATH Y	ES 🔲	NO 1	UN	CERTAIN	10			
The lase has te Del	PHYSICIAN:	25. WAS CASE REFERRED T EXAMINER?	O MEDICAL		26.	PLACE OF DE)					
tificat e Star	Sic	YES 2 NO		HOSPITAL:	ER/Outpatia	int 3 🗆 DOA	4 Nu		me 5 🗆 R	lasidenca	6 Other (Specify)			
fysic is cer ith th	H	27. MANNER OF DEATH	Se 5	28s. DATE Of (Month, I	F INJURY Day, Year)	26b. TI	ME OF		JURY AT		26d. DEŞCRIBE HOW	INJURY OC	CURED	
VG Ph ter th sath w mark	В		Pending Investigation				М		YES 2	_ NO				
ENDIP OR: At ter de	ED		Could not be determined	28s. PLACE (building	of Injury — . , atc. (Specify)	At home, farm.	, street, fac	tory, affi	lca	1	28i. LOCATION (Street City or Town, State		r or Rural A	oute Number,
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate it or THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physic be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prix IMPORTANT: If item 28 is marked, or Nem 23 shows any injury, or other th														
AL DI AL DI 72 ho	MPL	combon only									to the cause(s) and m			
UNER ITHIN	00	2 MED	ICAL EXAMINE	R: On the basis of a	examination an	nd/or investigat	ion, In my	opinion,	death occu	ared at the	time, data and placa, a	ind due to t	he cause(s)	and manner as stated.
THE FINE WIND	BE	29b. SIGNATURE AND TITLE	mil /	Sour	MA				29c. LIC	ENSE NUM	BER	29d. DA	E SIGNED	(Month, Day, Year)
E 2 2	5	' //		10-01	, , ,				\cup	121	5 7 0		CIOO	er 23,199;
17		30. NAME AND ADDRESS OF	10 M	RA1				110	10	with	ento 1	12	200	er 23, 1999.
10		31. DATE FILED (Month," Day,		32, REGISTE	AR'S SIGNATU	3941	rel	al	<u>a</u>	~//0	ain 19	4	2076	70
			995	32. REGISTR	Gor Rano	lall					,			
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

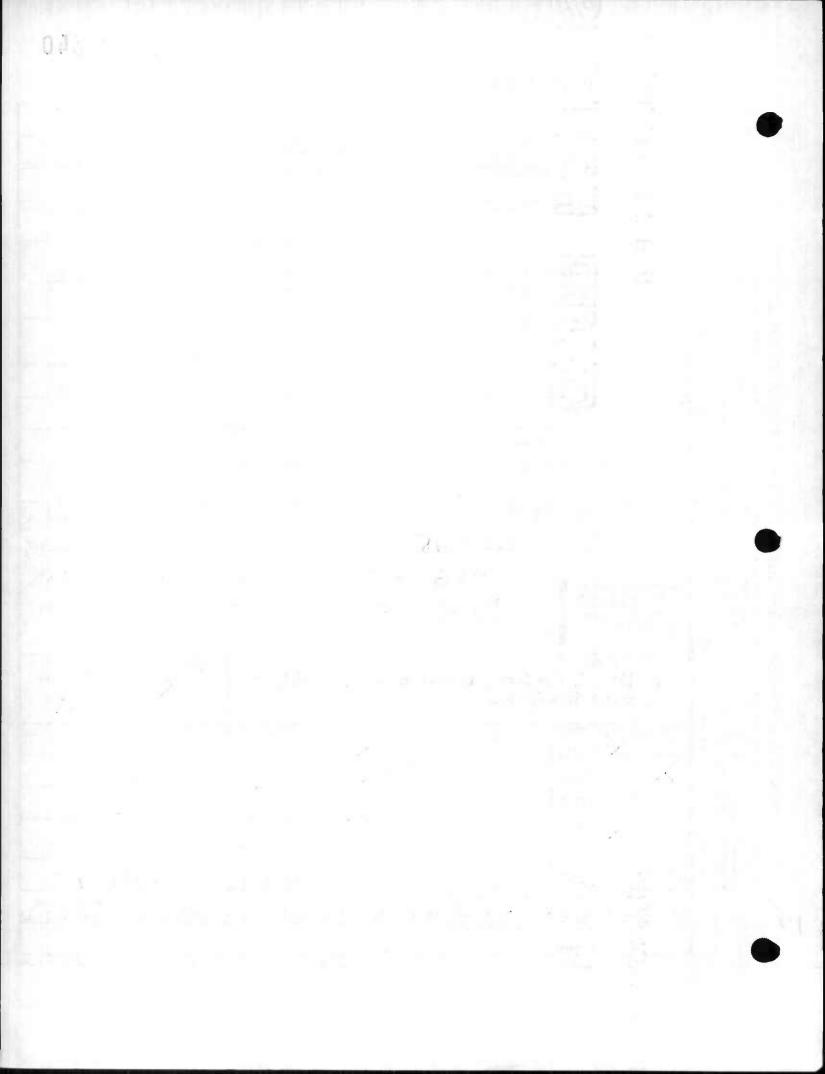
ALTIMORE, MARYLAND 21215-0020

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HE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within whours after death. Page 6 may be retained by the hospital or attending physician.	CTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit, Pages 1, 2, 3 should	s after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	PORTANT: It Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
E HOSPITAL OR ATTENDING PHYSICIA	E FUNERAL DIRECTOR: After this certif	be filed within 72 hours after death with the	RTANT: It item 28 is marked, or

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

_	REGISTRAR				CERTIF	ICAIC	UF	DEAL	l III	F	REG. NO.			
	1. DECEDENT'S NAME (First, M Joyce Berr		te Dre	scher						2. DATE OF MONTH	DEATH DA	<u> </u>	YEAR 95	3. TIME OF DEATH 5:20 DIN M
	4. SOCIAL SECURITY NUMBER	3	5. SEX	6. AGE (In yrs	. last birthday)	IF UNDER		IF UNDER		7. DATE OF	BIRTH		a, BIRTH	IPLACE (State or Foreign
	215-50-5290		1 □ M 2 🎇 F	47	YRS.	MONTHS	DAYS	HOURS	MIN.	March		948	Wash	ington D.C.
	9a. FACILITY NAME (If not institution, give street and number)					9b. CITY	TOWN	R LOCATIO	ON OF DE			9c. COUNTY OF DEATH		
OR	Frederick 1	Health	Care C	enter		Frederick				k	Frederick			rick
5	RESIDENCE OF DECE	OENT 0b. COUNTY			40. 017	Y, TOWN D	D 1 001							
DIRECTOR					100. 011	i, iown c			. 1					10d. INSIDE CITY LIMITS?
	Maryland 10e. STREET AND NUMBER	МО	ntgomer	У				zip copi	sbur	g		10a CIT	IZEN OF V	1 YES 2 X NO
FUNERAL	The state of the s	n 4 4 ~ ~ 1	des Ded				1.0		2087	0		-		
Ž I	11. MARITAL STATUS		ine Dri		ARMED	13 1	WAS DEC	-		9 IC ORIGIN? (S	nanth Yes			States E - American Indian,
	1 Never Married 2 Ma		FORCES? 1	YES 2	ND		f yes, sp	ecify Cuba		, Puerto Rica		01 110 —	Black Spec/	k, White, etc.
B	3 Widowed 4 Divorce	ıd	,	WIII OII DAILO			_ 1es	z M HO	apacity.				apeci	White
	15. DECED (Specify only h	ENT'S EDUCA		16a	. DECEDENT'S (Give kind of	USUAL O	CCUPATIO	ON at of workin	na	16b. KII	OF BUS	INESS/IN	DUSTRY	
COMPLET	Elementary/Secondary (0-12		College (1-4 or 5		Ille. Do NOT us	se retired.)								
M			4	A	dminis	trat	ive						nmen	t
8	17. FATHER'S NAME (First, Midd							18. MOTI	HER'S NAM	WE (First, Midd				
BE			Dresche	r						Chris				
2	19a. INFORMANT'S NAME (Type									loute Number,				1 20070
	Joanne M 20a, METHOD OF DISPOSITION		er	205 191 4	1230					-	_		City or To	and 20878
	1 N Buriel 2 Cremation 4 Donation 6 Other (S)	3 🗌 Remov	al from State	cometery Sai	ceand date						Bar	nesv	ille	, Maryland
	21. SIGNATURE OF FUNERAL S	SERVICE LICE	NSEE	7		Ro.	bert	D ADDRES	Pump	hrey 1	Tuner	al H	lome/	100
	1)0	, 9	South	∠ M003	35	Ro	ckvi	lle,	Inc	. 300 vland	West	Mon	itgom	ery Avenue
	23. PART I. Enter the dise	asea, or co	mplications the	it caused the	death. Do	not enter	the mo	de of dy	ing, such	as cerdied	or reapi	retory ar	reat,	Approximate
	IMMEDIATE CAUSE (Finel		at only one cau	use on each	line.									Interval Between Onset and Deeth
	disease or condition resulting in death)		SE	EPS1	518									2 weeks
	Tooling III county	SEQUENCE O	NCE OF):											
Z	Sequentially list conditions a GHWGRENE									lweete				
	Sequentially list conditions, if eny, leading to immediate								20					
2	cause. Enter UNDERLYING CAUSE (Disease or Injury		DUE TO	(OR AS A COA	= &	27								30 year
HILICATION	that initiated events resulting in death) LAST	- 1	000 10	(On AS A CON	SEDUENCE O	r):								
		d.												
AL	PART II. Other eignificent	conditiona	contributing to	deeth but n	ot resulting	in the un	deriyin	g couse (given in I	Part I. 24	a. WAS AN		24b.	. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
	FND	STA	-6t	PE	NA		DI	SEV	ME	1	YES 2	NO		COMPLETION OF CAUSE
Z L	DEPR	ESS	10h									/		1 TES 2 NO
ž														
PHYSICIAN: M	25. WAS CASE REFERRED TO I	4	HOSPITAL:			QTHE		ACE OF D	EATH (Che	ick only one)				
2	1 YES 2 NO	1	Inpetient 2			4 Hun	sing Hon		nsidence	6 Other (S				
	1 Natural 5 Pe	nding		Day; Ybar)	28b. TIM	URY		RK2	7.40	28d, DESCR	BE HOW II	NJURY OC	CURED	
2		restigation	NOV	E INJURY - A	t home form	at most from	1 🗌		MO	204 1 00471	3AL (0			Duran Museum
MPLEIEU		uid not be termined	building.	etc. (Specify)	a nome, man,	street, rect	ory, orne			City or T	own, State)	ind Numoe	r or nursi r	Route Number,
	29n. CERTIFIER	VIND BUVEIO	ANI. To the best of										_	
Z	(Check only		AN: To the best of											n) and manner as stated.
3	29b. SIGNATUBÉ AND TITLE O					,, .	piilioit, t				piece, un			
N N	1 H La Ma	LEKTIFIER	MI)				Z9c, LICI	ENSE NUM レフ (BER		29d, DAT	SIGNED	(Month, Day, Year)
27	30. NAME AND ADDRESS OF P	ERSON WHO	COMPLETED CALL	SE OF DEATH	(ITEM 27) /7/200	Print)		D	1/3	10		- /(1/d	0/73
	WILLIAM	HE	ENRY	JUL	OZUH	N	5	T	HUM	ASJO	HAIC	CND	P	REDERICK
	31. DATE FILED (Month, Day, Yes	nr)	32. REGISTR	AR'S SIGNATUR	RE.	. 7		,,,	,	.,,, - (2,7,03	J.7P	<i>i</i> C'	MO 21702
	DOT 25	1005	61: As	wiles Ro	1111									
	المناء البلاء	1447	PARTICIAN DIST	Section 1716	EVIA U									



BALTIMORE, MARYLAND 21215-0020

FOR

MINISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020	TO THE MOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within = hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	m 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
DIVISION OF	TO THE HOSPITAL DR ATTENDING PHYSI	TO THE FUNERAL DIRECTOR: After this co	IMPORTANT: If item 28 is marked,

	FOR 1 - STATE REGISTRAR	STATE OF MARYLA	ND / DEPAI					MENTAL	HYGIENE REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Leat)		0211111					2. DATE O	F DEATH			3. TIME OF DEATH
	Edward A. Downey							Octo	ber 22		YEAR	8:50P M
	4. SOCIAL SECURITY NUMBER	5. SEX 8. AGE (Ir	yrs. last birthday)			IF UNDER		7. DATE O				PLACE (State or Foreign
	506-07-2597A	1 🛱 M 2 🗆 F 💮 8	35 YRS.	MONTHS	DAYS	HOURE	MIN.			1910 Nebraska		
	9a. FACILITY NAME (if not institution, give str	eet and number)		9b. CITY	, TOWN C	OR LOCATION OF DEATH					ITY OF D	
OR	Manor Care-Bethes	da		Che	vy C	hase				Mor	itgon	nery
DIRECTOR	RESIDENCE OF DECEDENT 10a, STATE 10b, COUNTY		I the Ci	TY, TOWN (OR LOCAT	ION						10d. INSIDE CITY
18												LIMITS?
	Maryland Mont	tgomery	I Ke	ensin		ZIP CODI	E			10g, CITI	ZEN OF W	HAT COUNTRY?
FUNERAL	10218 Oldfield	1 Drive				208	95			IIı	nite	d States
S	11. MARITAL STATUS	12. WAS DECEDENT EVER IN				ENOENT C	F HISPAN		(Specify Yes			— American Indian,
	1 Never Married 2 Married	FORCES? 1 X YES	2 NO			2 X NO		n, Puerto Ri y:	can, etc.)		Specia	ly:
ВУ	3 🔀 Widowed 4 🗌 Divorced		WW II									White
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade of		(Give kind of	work done			ng	16b.	KIND OF BUS	INESS/IND	USTRY	1777
삗	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT		0	1						
ME	17. FATHER'S NAME (First, Middle, Last)	4	Distrib	utloi	1 00	_			epartn		Stoi	е
	William A. Downe	2.57							Bohana			
BE	19a. INFORMANT'S NAME (Type/Print)	<u> </u>	19b. MAILIN	O ADDRESS	S (Street a				or, City or Town		Codel	
5	Douglas W. Kresho	nver							Virg			180
	20s. METHOD OF DISPOSITION	20b.	PLACE AND DATE	OF DISPOS	SITION (No	me of		OATE		ATION -		
	1 Donation 5 Other (Specify)	val from State Come	ntgomer	v Cre	Octo	ber	24 I	1995	Beth	esda	, Ma	ryland
	21. SIGNATURE OF FUNERAL SERVICE LICE											
	· mil	5 0X6-00.	M00846	5 Çh	evy	Chas	e, I	nc.	7557	Wisc	ome,	Bethesda- n Avenue
	23. PART I. Enter the diseases, or cahock, or heart failure. L	omplications at 1 caused	the death. Do	not enter	the mo	de of dy	Mary Ing, suc	th as cardi	ac or reaple	ratory an	wat,	Approximate
		iat only one sense on ea	ich line.									Onset and Death
	iMMEDIATE CAUSE (Final disease or condition	Pneumonia										2 Days
	resulting in death) DUE TO (OR AS A CONSEQUENCE OF):											
z	Sequentially list conditions b.											
0E	Sequentially list conditions, if any, leading to immediate											
2	cause. Enter UNDERLYING CAUSE (Diseese or injury	DIE 70 (00 40 4	CONSTONENCE	0.00								
Ë	that initiated events resulting in death) LAST	DUE TO (OR AS A	CONSCOUENCE	OF):								
CERTIFICATION												
AL (PART II. Other aignificant conditions					g cause	given in	Part i.	24a. WAS AN		24b	WERE AUTOPSY FINDINGS
C	Pulmonary Embol:	i, Congestive	Heart	Fail	ure				1 YES 2	37		COMPLETION DF CAUSE OF DEATH?
MEDI												1 YES 2 NO
ż	DID TOBACCO USE CONTR					UNC	ERTAI	N 🗆				
SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF OE	OTHE								
YSI	1 TES 2 NO	1 Inpetient 2 I ER/Outp		4 CZNu	raing Hon		esidence	6 🗆 Other				
PHY	27. MANNER OF DEATH 1 X Natural 5 Pending	(Month, Day, Year)		ME OF NJURY	WC	DRK?	7 440	28d. DES	CRIBE HOW II	NJURY OC	CURED	
BY	2 Accident Investigation	28e. PLACE OF INJURY	— At home form	etraal fac		YES 2	NO	281 1 001	TION (Street a	and Mumba	or Dural I	Boude Mumber
ETED	3 Suicide 8 Could not be determined	building, etc. (Spec		, atter, lac	nory, orne				or Town, State)	rica (Marriapon	Or Horal r	Number,
Ē	29a. CERTIFIER											
MPI	(Check only	CIAN: To the best of my knowl R: On the basis of examination										a) and manage as stated
COMPL	-		and/or investige	ittori, ili irriy	оринот, с				and prace, an			
BE	290 SIGNATURE AND TITLE OF CERTIFIER	1-11	10 5			D04	766	WBER				(Month, Day, Year)
0	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DE	ATH (ITEM 27) 4	Da Princt			, 55			- 0	CLOD	er 23, 1995
	Daniel Rosenblum) Conne		+ Δτ	enue	. #6	506 1	Zensin	oton	, MD	20895
				cercu	CAV	CHUC	<i>)</i> 11 C	,00, 1	CHOTH	Prom	, 1111	20073
	31. DATE FILED (MONTE CAN YEAR) UC 25 1995	32. REGISTRAR'S SIGN	lardall									

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TIMORE, MARYLAND 21215-0020

FOR STATE REGISTRAR

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DIVISION OF VITAL RECORDS, P.O. BOX 68760	I DR ATTENDING PHYSICIAN: The Is
NISION	ATTENDING
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1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATN 3. TIME OF DEATN YEAR OCTOBER MALLIIM DUNHAM 8:15P M 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. lest birthday) 7. DATE OF BIRTH (Month, Day, Year) IF UNDER I YEAR IF UNDER 24 HRS. 8. BIRTNPLACE (State or Foreign Country) 1 K M 2 | F MONTHS DAYS HOURS MIN. 220-44-8512 VDC JUNE 23,1905 NEW YORK Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATN DIRECTOR FAIRLAND NURSING HOME SILVER SPRING MONTGOMERY RESIDENCE OF DECEDENT 10e STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MD. MONTGOMERY SILVER SPRING permit. 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? page 5 should be detached for use as the burial-transit 9318 COLESVILLE RD. 20901 U.S.A. Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yee or No-If yes, specify Cuber, Mexican, Puerto Rican, atc.) 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 1 Never Married 2 Married 1 YES 2 NO Specify BY Specify: 3 Widowed 4 Divorced 1922-1953 WHITE COMPLETED 15. DECEDENT'S EDUCATION 16s. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade College (1-4 or 5+) Elementary/Secondery (0-12) AVIATOR AND OFFICER U.S. NAVY 17. FATHER'S NAME (First, Middle, Last) 16. MOTNER'S NAME (First, Middle, Meiden Surname) F WILLIAM DUNHAM IRENE BE FOWLER notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 HELEN M. DUNHAM SAME AS ITEM Pe 20e. METHOD OF DISPOSITION
1 Description | Burlet | 2 | Cremation | 3 | Removal from State | 4 | Donetion | 5 | Other (Specify) | 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State must DATE director, ARLINGTON NATIONAL CEMETERY 10/27 ARLINGTON. VA. examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY funeral (W. W. CHAMBERS CO. INC., SILVER SPRING, MD. M00091 filled in by the medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. interval Between ŏ IMMEDIATE CAUSE (Final Onset and Death cremation, the disease or condition ____ and completely fi o burial, cremation CHRONIC OBSTRUCTIVE PULMONARY DISEASE 4 hrs event. DUE TO (OR AS A CONSEQUENCE OF): LEFT LOWER LOBE PNEUMONIA traumatic CERTIFICATION 2 wks Sequentially list conditions, 20 DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING physician ne prior to a HYPERTENSION CAUSE (Disease or Injury YEARS the attending phy Mental Hygiene DUE TO (OR AS A CONSEQUENCE OF): that initiated eventa resulting in death) LAST 10 Injury, PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS and a AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? shows any ALZEHEIMERS Signed Health a 1 TES 2 NO BLADDER OUTLET OBSTRUCTION 1 | YES 2 | NO t. of I DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: has b Dept. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) the State EXAMINER? HOSPITAL: OTHER:
4 ② Nursing Name 5 ☐ Residence 6 ☐ Other (Specify) Inpatient 2 - ER/Outpatient 3 - DOA 6 27. MANNER OF DEATN
1 Natural 5 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d. DESCRIBE NOW INJURY OCCURED marked. with w 5 Pending 1 YES 2 NO BY After death Investigation 2 Accident 26f. LOCATION (Street end Number or Rural Route Number, City or Town, Stete) 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 3 Suicide 09 COMPLETED 6 Could not be DIRECTOR: 4 Nomicide 82 determined Item 29e. CERTIFIER
(Chack only 1 💢 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end manner as stated. FUNERAL within 72 I 2 MEDICAL EXAMINER: On the besie of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) end manner ee stated. TO THE HOSPITA
TO THE FUNERAL
DE filed within 72
IMPORTANT: II 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE Armstrong M.O. atricia) 0. D42618 OCTOBER 21. 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print) ARMSTRONG, MD PATRICIA S. 14440 CHERRY LANE LAUREL . MD 31. DATE FILED (Month, Day, Year) 32, REGISTRAR'S SIGNATURE OCT 25 1995 Jalia Davidson Randall

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

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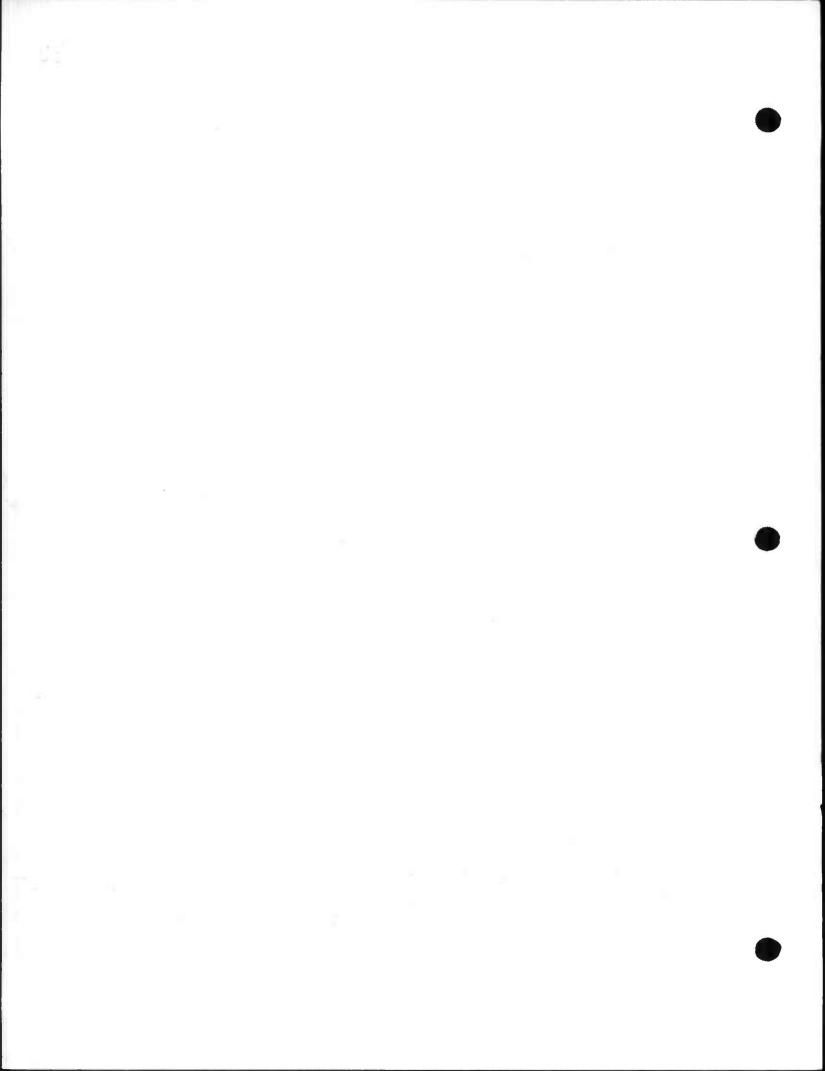
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examiner must be notified at once.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
e funeral director, page 5 should be detached.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache be filed within 72 hours after death with the State Dept. of Reath and Mental Hygiene prior to burial, cremation, or removal.
death. Page 6 may be retained by the hosp	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Z4 hours after death. Page 6 may be retained by the hosp

	1 - FOR STATE REGISTRAR	STATE OF MARYL		PARIMEN FIFICAT				TAL HYGIEN REG. NO.	E		
1	1. DECEDENT'S NAME (First, Middle, Last)	Vivian Eli					2, 1	pate of DEATH DATE OF DATE		3. TIME OF DEATH 95 1:55 A. M	
	4. SOCIAL SECURITY NUMBER 579–14–8347	5. SEX 6. AGE	(In yrs. last birtho	MONTHE	R 1 YEAR	IF UNDER 24 I	HRS. 7, [DATE OF BIRTH	8.	BIRTINPLACE (State or Foreign Country) Washington, D. C	
8	90. FACILITY NAME (If not Institution, give s 14802 Kimberwic			9b. CITY, TOWN OR LOCATION OF DEATN BOWIE					9c. COUNTY OF DEATH		
5	RESIDENCE OF DECEDENT								PLIN	ce George's	
DIRECTOR		ce George's		owie						10d. INSIDE CITY LIMITS? XX YES 2 \(\text{NO} \)	
FUNERAL	14802 Kimberwick	Drive			101,	20715	õ			ted States	
B	11. MARITAL STATUS 1 Never Merried 2 Merried 3 National American	12. WAS DECEOENT EVER FORCES? 1 TYES	NUS ARMED 2 XXIO PATES	13.	If yee, spe	ENDENT OF H	lexicen, Pu	RIGIN? (Specify Yes erto Ricen, etc.)	or No.— 14	RACE — American Indian, Black, While, etc. Specify: White	
TED	15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	16a. DECEDER	NT'S USUAL C of of work done OT use retired.)	OCCUPATIO during mos	N at of working		16b. KIND OF BUS	SINESS/INDUS	TRY	
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)		Estate				Privat	e		
BE CO	17. FATNER'S NAME (First, Middle, Last) Joseph L. Griffi	n				18. MOTNER UNKNO		First, Middle, Melden	Surneme)		
TO B	190. INFORMANT'S NAME (Type/Print) Gary Devlin		19b. MAII	ILING ADORES	S (Street er S #10	Number or	Rural Route	Number, City or Town	n, State, Zip Co	rde)	
	20s_METNOO OF DISPOSITION 1 AL Burlel 2 □ Cremetlon 3 □ Rem 4 □ Donation 5 □ Other (Specify)	oval from State	DELECT CIETARD							or Town, State , Maryland	
	21. SIGNATURE OF FUNERAL SERVICE LIN	CENSEE DOLL VOLL	11	D	ona1	d V. E	Borgw	ardt Fun	eral H	Home, P.A.	
	23. PART I. Enter the diseases, or shock, or haert fellure. IMMEDIATE CAUSE (Final disease or condition resulting in daeth)	complications that cause List only one cause on a a. DUE TO (OR AS	TALIC	Do not anta	r tha mod	da of dyling.	, auch aa	cardiac or reapi	ratory arrest	Approximate Interval Between Onsat and Death	
CERTIFICATION	Sequentially list conditions, if any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):										
CE		d									
EDICAL	PART II. Other algolificant condition	e contributing to death i	out not reaulti	Ing In tha u	nderlylng	ceuse give	en In Part	I. 24a. WAS AN PERFOR	MEO?	24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
Σ	DID TOBACCO USE CONT	RIBUTE TO CAUSE O	OF DEATH	YES 🗆	NO 🗆	UNCER	TAIN É	4		1 TYES 2 NO	
Sici	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 MO	HOSPITAL:	28. PLACE OF	OTHE	R:	1-					
PHYSICIAN:	27. MANNER OF DEATN	1 Inpatient 2 ER/Out		TIME OF	28c. INJU WOF	IRY AT		Other (Specify) DESCRIBE NOW II	NJURY OCCUR	DED	
B⊀	1 Natural 5 Pending 2 Accident Investigation	28e. PLACE OF INJURY	/ — At home, to	M etraet fac	1 🗌 Y	1-6	_	LOCATION (Stead of	and Mireshan an	Sund State Market	
ETED	3 Suicide 8 Could not be determined 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)							281. LOCATION (Street end Number or Rural Route Number, City or Yown, Stete)			
COMPLET		ICIAN: To the best of my know								euse(e) end menner se stated.	
шШ	296 THOMATUNE AND TITLE OF CERTIFIE	Sherre				10c. LICENS	E NUMBER	. 1	29d. DATE SI	IGNEO (Month, Day, War)	
TO B	(8) MANAE AND ADDRESS OF PERSON WA	Q COMPLETED CAUSE OF DE	ATH (ITEM 97 /	Time Drivet		DU	1/5	4	► 10	120/95	
	THOMAS A. F	NO NO P	2 mg	25	25	GR	EEA	way Cl	n. Div	e Greenbell m	

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NEGISTRAR'S SIGNATURE
D'AUGUST- CONCELL

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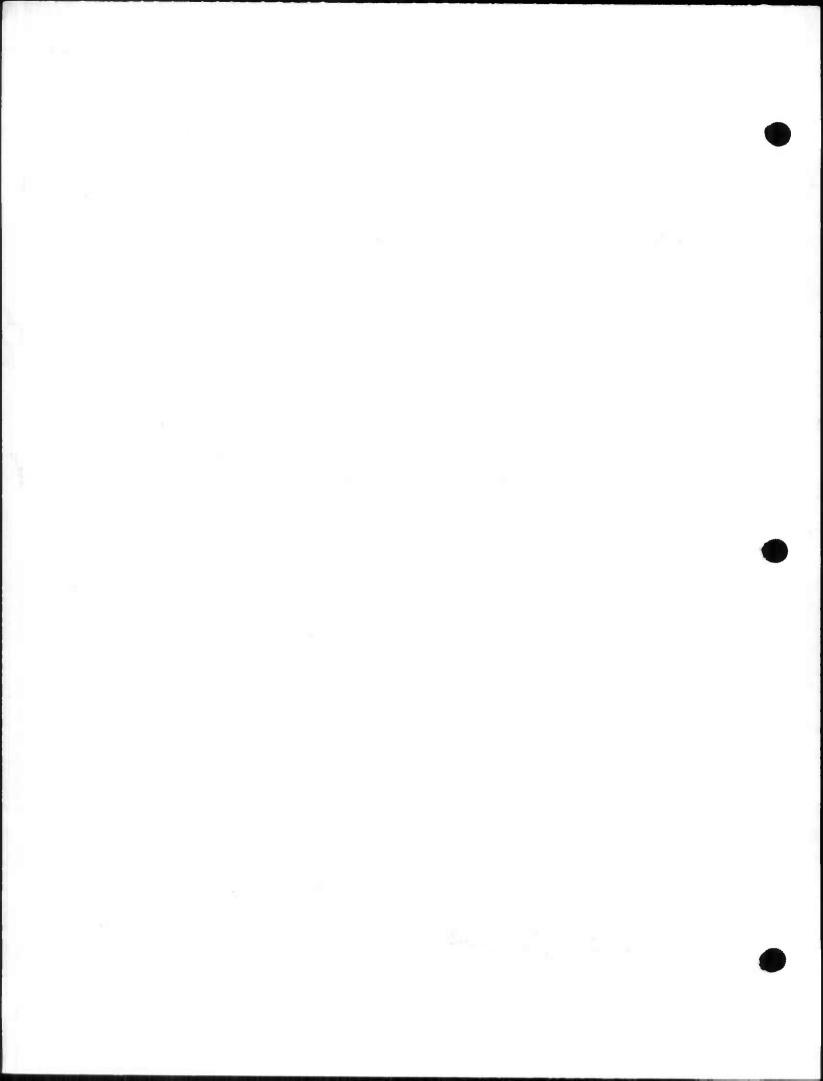


TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: if item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

-	FOR STATE REGISTRAR	STATE	0
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F MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR	CERTIFIC	ATE OF	DEATH		REG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF	OEATH		. TIME OF OEATH		
	MARY L ENNIS October 20 95 8:10 1									
		yrs. last birthday) II	F UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF			LACE (State or Foreign		
		MC MC	INTHE DAYS	HOURS MIN.	(Month, I	Day Year)	MARY	T A 3TD		
	219-26-4442 1 D M 2 😾 F 59	YRS.			NOV.	4 1935	MARY	LAND		
	9a. FACILITY NAME (If not institution, give street and number)	9	b. CITY, TOWN (R LOCATION OF DE	ATH	9c, C0	DUNTY OF DEA	ТН		
Œ	Novell A word Harristal	FLEN BURNIE MD				ANNE Arundel				
DIRECTOR	North Arundel Hospital RESIDENCE OF DECEDENT) ==	Jenne,	עוייו		1114/16	/ H W MOYEY		
<u>입</u>	10e. STATE 10b. COUNTY	Inc. CITY 1	OWN OR LOCAT	TON			1	IOd. INSIDE CITY		
2	Comment of the commen			1011			1.0	LIMITS?		
	MARYLAND ANNE ARUNDEL	ODE	NTON					XYES 2 NO		
	10e. STREET AND NUMBER		10	ZIP COOE		10g. C	TIZEN OF WH	IAT COUNTRY?		
2	1421 JACKSON ROAD	21113			USA					
FUNERAL	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U	I C ADMED	40 200 050		NO ODIONIO	Maria Maria Na				
3	1XX Never Married 2 Merried FORCES? 1 YES	13. WAS DECENDENT OF HISPANIC ORIGIN If yes, specify Cuban, Mexican, Puerto R 1 ☐ YES 2 ☒ NO Specify:			Rican, atc.) Black, Wh		- American Indian, White, atc.			
B	3 Widowed 4 Divorced	Specify:								
							BLAC	K		
Ш	15. DECEDENT'S EQUICATION (Specify only highest grade completed)	6a. DECEDENT'S US (Give kind of work			16b. K	IND OF BUSINESS/	NOUSTRY			
	Elementary/Secondary (0-12) College (1-4 or 5+)	life. Do NOT use r	etired.)	at of months						
COMPLETED	9th 0	HOMEMA:	KER			OWN HOME				
2	17. FATHER'S NAME (First, Middle, Last)			18 MOTHER'S NA	ME (First Mic	Idle, Maiden Surname	1			
Ö							,			
BE	CLARENCE ENNIS					ORMLEY				
	19a. INFORMANT'S NAME (Type/Print)	19b. MAILING AI	ODRESS (Street I	and Number or Rural i	Route Number	City or Town, State,	Zip Code)			
5	PATRICIA SCRIVNER	1421 J	ACKSON	RD. ODEN	TON.	MD. 2111	3			
		LACE AND DATE OF			DATE	7		n. Stata		
	SEL Bright & C. Commettee & C. Bermand from State				1			MD. 21401		
		NAPOLIS !				ANNAP	ULIS,	MD. 21401		
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE			ND ADDRESS OF FA		ARY, P.A				
	* Harry 12. Fees	9								
-						OLIS, MD				
	23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardisc or respiratory arrest, ahock, or heart feliure. List only one cause on each line. Interval Between									
	Onset and Daeth									
- 1	disease or condition									
	resulting in death) s. REST ACCY (RECOVER)									
- 1	IMMEDIATE CAUSE (Fins) disease or condition resulting in death) s. Pessivatory Coulour Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):									
Z	Sequentially list conditions, The Electrolytis Competition, Here Level L									
Ĕ	if any, leading to immediate									
3	cause. Enter UNDERLYING CAUSE (Disease or Injury									
E.	that initiated events DUE TO (OR AS A C	CONSEQUENCE OF):								
F	resulting in death) LAST									
CERTIFICATION										
	PART II. Other significant conditions contributing to death but	not resulting in	the underlyin	g csuae given in	Part I. :	4a. WAS AN AUTOP!		WERE AUTOPSY FINDINGS		
MEDICAL						PERFORMED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE		
ā					— I	YES 21 NO		OF DEATH?		
#							1	1 YES 2 NO		
	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN									
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)									
S	EXAMINER? 1 YES 2 NO 1 Inpatient 2 ER/Outpet		THER:		. O .					
ΥS				ne 5 🗌 Rasidenca						
표	27. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year)	26b, TIME (JURY AT ORK?	28d. DESC	RIBE HOW INJURY	OCCURED			
ВУ	1 Netural 5 Pending Investigation		M 1 🗆	YES 2 NO						
	3 Suitelds 28e. PLACE OF INJURY -		et, factory, offic	:8		CATION (Street and Number or Rural Route Number, y or Town, State)				
Ш	4 Homicide determined building, etc. (Specifi	7)			City or					
COMPLETED	and CERTIFIED	-								
7	29a. CERTIFIER (Check only (Check only)	dge, death occurred	at the time, date	and place, and due	to the caus	e(a) and menner as	stated.			
2	one) 2 MEDICAL EXAMINER: On the basis of examination	and/or investigation,	In my opinion,	death occured at the	time, deta a	nd place, and due t	o the ceuse(s)	and manner as stated.		
	29b. SIGNATURE AND TITLE OF CERTIFIER			29c. LICENSE NU	MBED	1 204 1	TATE SIGNED	Month One West		
BE			29d. DATE SIGNEO (Month, Day, Year)							
0 4377										
F	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEAT	TH (ITEM 27) (Type, P	rint) 190 -	ol ulin.	Lind 1	week	NOU			
	Mohamed S. Moubarell		Gara	non Tinan		MID .	20912	224		
	31. DATE FILED (Month, Day Year) 32. REGISTRAR'S SIGNAT	TURE##	SENI		. –	- 41	0 0 7	7		
	OCT 2 6 1995	CALL!								



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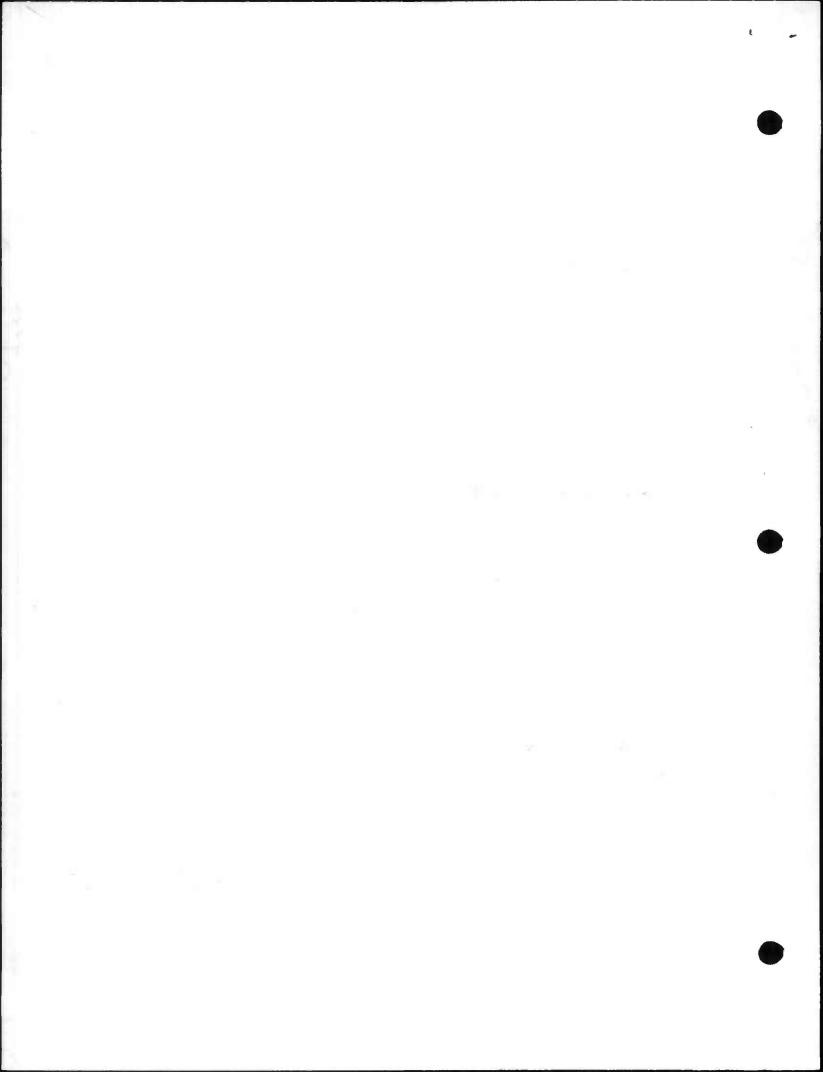
1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

		1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF DEATH MONTH D	AY YEAR	3. TIME OF DEATH	
			Walter Fra					October 1		11:40 pm	
		4. SOCIAL SECURITY NUMBER 216 - 36 - 3669	5. SEX 6. AGE	E (In yrs. lest b	VRS. IF UNDER	1 YEAR DAYS	IF UNDER 24 HRS. HOURS MIN.	Sept 25,1	8. BIRT	HPLACE (State or Foreign try) ryland	
3 should		9e. FACILITY NAME (If not institution, give st	reet end number)	31	9b, CITY	TOWN C	OR LOCATION OF DE		9c. COUNTY OF	-	
6,	TOR	8438 Leishear Road Laurel Howard									
iges 1.	DIRECTO	10e, STATE 10b, COUNTY			10c. CITY, TOWH C	R LOCAT	TION			10d. INSIDE CITY	
permit. Pages		Maryland Howar	đ		Laurel					LIMITS? 1 YES 2 X NO	
ışı	IERAL	8438 Leishear Roa	đ		101. ZIP CODE 10g. CITIZEN C					WHAT COUNTRY?	
020 physician. burial-transit	FUN	11. MARITAL STATUS 1 Never Merried 2 Merried	12. WAS DECEDENT EVER FORCES? 1 YES	2 X NO	2 NO If yes, specify Cuben, Mexico			IC ORIGIN? (Specify Yes	or No- 14. RAC	E — American Indian, ck, White, etc.	
215-0020 attending physician se as the burial-trai	B 6	3 🔀 Widowed 4 🗌 Divorced	IF YES, GIVE WAR OR	DATES		☐ YES	2 XNO Specify	<u> </u>	Wh	ite	
21215 al or attend for use as	ETED	15. DECEDENT'S EDUC (Specify only highest grade	completed)	(Give	EDENT'S USUAL OF kind of work done to NOT use retired.)	CUPATIO	ON est of working	16b. KIND OF BUS	SINESS/INDUSTRY		
The hospital detached for	APE .	Elementary/Secondary (0-12) Grade 10	College (1-4 or 5+)	1	ck Drive	r		Concret	te Compa	ny	
LAND the hospit	COMPL	17. FATHER'S NAME (First, Middle, Last)						ME (First, Middle, Malden		•	
Ed by	BE at	Samuel Ecker		1			Helen I				
BALTIMORE, MARYLAND 21215-0020 let death. Page 6 may be retained by the hospital or attending physic the funeral director, page 5 should be detached for use as the burial real.	TO BE	Kenneth Ecker						oute Number, City or Tow		0723	
BALTIMORE, hours after death. Page 6 may be bed in by the funeral director, page or removal.	must be	20e. METHOD OF DISPOSITION 1 X Burlel 2 Cremation 3 Remo		Db. PLACE AND	D DATE OF DISPOS	TION/Na	ame of	DATE 20c. LO	CATION — City or 1	own, State	
Page 6	Ē	4 Donation 5 Other (Specify)		hrist	church		etery O ADDRESS OF FAC	10/21 Co.	lumbia,	Maryland	
ALT seath.	examiner	· 1/1/1/2	Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, Maryland 20707								
B after of the removal.		23. PART I. Enter the sleepases or c	omplications that cause	ed the deati	h. Do not anter	the mo	ralbott F	Ave. Laure.	I, Maryl	Approximate	
ely fill, artion,	event, the medical	shock, of heart filture. I IMMEDIATE CAUSE (Finst disease or condition resulting in death)	ist only one rause on	each line.	ma			To Cardia of Teap	atory street,	Interval Between Onset and Death	
P.O. BOX 68 th certificate be execute tending physician and or Il Hygiene prior to buria	or other traumatic	Sequentially list conditions, if any, leading to immediate cause, Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST									
RDS at the o	100	PART II. Other algolificant conditions	contributing to death	but not rea	ulting in the un	darlying	cause given in i	Part I. 24a. WAS AN PERFOR		24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO	
O E P -	MEDICAL			·				1 TYES 2	Die	COMPLETION OF CAUSE OF DEATH?	
W red	T	DID TOBACCO USE CONTR	IBUTE TO CAUSE (OF DEATH	1 YES T	10 🗆	UNCERTAIN			1 YES 2 NO	
The la	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	28. PLACE (OF DEATH (Check of						
SICIAN: The certificate h	HYS	1 YES 2 NO	1 Inpatient 2 ER/Out 28e. DATE OF INJURY		DOA 4 Num	ing Home	5 desidence				
ON O DING PHYS After this death with	BY Pt	1 Naturel 5 Pending 2 Accident Investigation	(Month, Day, Year)		INJURY M	WO	PK?	28d. DEŞCRIBE HOW II	NJURY OCCURED		
TTENDI STOR: A after da		3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF INJUR building, etc. (Spe	Y — At home, ecify)	, farm, street, lacte	ery, office		28f. LOCATION (Street e City or Town, State)	and Number or Rural	Route Number,	
L DIRECT	COMPLETED	290. CERTIFIER (Check only 1) CERTIFYING PHYSIC	IAN: To the best of my know	wledge, death	occurred at the ti	me, date	end place, and due	to the cause(a) and man	ner as stated.		
THE HOSPITAL THE FUNERAL filed within 72 P	COM	2 MEDICAL EXAMINER	On the basis of examination							e) end manner ee stated.	
TO THE HOSPIT TO THE FUNERA De filed within 7	B	29b. SIGNATURE AND TITLE OF CERTIFIER	Weun				DE LICENSE NUM	42	DCT	(Month, Day, Year)	
= 12, -4 -4	\$ ₽	30 NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF D	EATH (ITEM 2	(Type, Print)) ~	272	(057.	D. / A	Cours	
20		31. DATE FILED (Month, Day, Year)	32. REDISTRAR'S SIG	NATURE _	C 191)	1	2/0/	Chredo	TOY H	COMPION	
		OCT 2 3 199	5 Jalia d'ave	dear Ro	rlath						

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		1 - FOR STATE REGISTRAR	STATE OF MARY	LAND / DE	PARTMEN TIFICAT	T OF H	EALTH AN	ID MEI	ITAL HYGIEN	E		
		1. OECEDENT'S NAME (First, Middle, Last)						2.1	DATE OF DEATH			3. TIME OF DEATH
	.	FREDERICK JAY ESSINGER OCTOBER									YEAR	1:30 MM
		1// 10 0005		E (In yrs. lest birti	MONTHS	OAYS	IF UNDER 24 H	M (Month, Day, Year)		Country	PLACE (State or Foreign
pinous			1 X M 2 🗆 F	70 Y	RS.				PRIL 30,			
6,3	DIRECTOR	9a. FACILITY NAME (If not Institute, give alreat and number) 9b. CITY, TOWN OR LOCATION OF DEATH National Institute of Health Bethesda Montgomery										
10es 1,	REC	10a. STATE 10b. COUNTY		10-	c. CITY, TOWN	OR LOCAT	TION				Т	10d. INSIDE CITY
permit. Pages		Florida Palm E	Beach	I	Delray	Beac	ch					LIMITS? 1 YES 2 NO
	ERAL	10e. STREET AND NUMBER					. ZIP CODE			10g. CITI	ZEN OF W	HAT COUNTRY?
020 physician. burial-transit	FUNE	2345 North West 14	th Street 12. WAS DECEDENT EVER	R IN U.S. ARMED	19		33445 ENDENT OF HI	SPANIC O	RIGIN? (Specify Yes	USA	14 0405	American Indian,
020 physi buria		1 Never Married 2 X Married	FORCES? 1 YE	S 2 NO	1.0	If yes, sp		exicen, Pu	erto Rican, etc.)	or No-	Black Specif	, White, etc.
21215-0020 al or attending physician for use as the burial-tra	ЭВУ	3 Wildowed 4 Divorced										hite
- 5 m	ETED	15. DECEDENT'S EDUCA (Specify only highest grade or	ompleted)	(Give kir	ENT'S USUAL Ond of work done NOT use retired.)	during mo			16b. KIND OF BUS	INESS/IND	USTRY	
ed of	PLE	Elementary/Secondary (0-12)	College (1-4 or 5 +)		er/Oper				Clathi	F	÷	
the hospital detached for	COMPL	17. FATNER'S NAME (First, Middle, Lest)		OWITE	er/oper	ator		S NAME (F	Clothi		LLIII	
\$ \$ \$ Z	ш	Bernard Essinger					Mabel	Har	ris			
MARYL retained-by t 5 should be notified at	TO B	19a. INFORMANT'S NAME (Type/Print)							Number, City or Tow			
- 3-8 0		Renee Essinger							. Delray			
otor.		1 Burtel 2 Cremation 3 X Remov		Ob. PLACE AND C				1		dbri		
		21. BIGHATURE OF PUNERAL SERVICE LICENSES 22. NAME AND ADDRESS OF FACILITY										140
ALTIM death. Page tuneral dire tuneral dire axaminer r		Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, Maryland 20707									20707	
after after by the move	Н	23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate										
a of ir		IMMEDIATE CAUSE (Final Onset and Death										
ompletely fills or cremation, event, the		disease or condition resulting in death)	RESPIRE DUE TO TOR AS	A CONSEQUEN	Arres	T				-		2 days 7 days
	z	,	Pheu	monia								7-dans
OX 68 OX 68 be execut sician and orior to buri	RTIFICATION	Sequentially list conditions, Due to (or as a consequence of):										
certificate ding physic hygiene print of ther tr	일	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events	DUE TO (OR AS	D dus	Plasia							Lugar
	H	resulting in death) LAST	(4.1.1.		o							1 0
deat deat deat atte	CE	PART ii Other significant conditions	anniethering to doubt	h	AI - I - Ab							
_ > 0 _	CAL	PART ii. Other significant conditions	contributing to death	out not resur	ting in the u	nderlying	g cause give	n in Part	PERFOR	MED?	- 12	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE
Sign Sign Sign Sign Sign Sign Sign Sign	EDIC/								1 YES 2	□ NO	1	OF DEATH?
S of beer	N.	DID TOBACCO USE CONTRI	BUTE TO CAUSE	OF DEATH	YES 🗆	NO [UNCERT	AIN D	d			1 TES 2 NO
N: The lav ficate has State Dep	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF	OEATN (Check							
SICIAN: The Certificate the State	YSI	1 YES 2 NO	Inputient 2 - ER/O			sing Nom	e 5 🗆 Rasider					
NG PHYSI fer this coath with marked,	r PHY	27. MANNER OF DEATN 1 Netural 5 Pending	(Month, Day, Year	Y 28k	INJURY		URY AT RK? (ES 2 NO		DEŞCRIBE NOW II	JURY OCC	CURED	
NOING NOING IS Mark	D BY	2 Accident Investigation 3 Suicide 6 Could not be	28e. PLACE OF INJUI building, etc. (St	RY — At home, fo	arm, street, fac			-	LOCATION (Street a	nd Number	or Rural Ac	oute Number,
OF VITA OR ATTENDING PHYSICIAN: The DIRECTOR: After this certificate h hours after death with the State I Item 28 Is marked, or item	COMPLETED	4 Homicide detarmined	building, etc. (3)	Jecliy)					City or Town, State)			
Z 7 Z	APL		AN: To the best of my kno									
HOSPITAL FUNERAL within 72 I	CO	2 MEDICAL EXAMINER:	On the beels of examinat	tion and/or invest	tigation, in my	opinion, d	eath occured at	the time,	data and place, an	d due to th	e cause(a)	and manner as stated.
TO THE HOSPIT TO THE FUNERA DE filed within ?	BE	296. SHEWARD MILE OF CONTROL	MAI IN.	D. D	h.D.		29c. LICENSE	NUMBER 2 47	77-1200	29d. DATI	SIGNED ((Month, Day, Year)
₽ ₽ ₽ ₹	2	30. NAME AND AODRESS OF PERSON WHO	108				11/1	0 16	15 1WS	11	1.55	117
						ILLE	PIKE	BETH	ESDA MAR	YLAND	208	92
_ 15		31. DATE FILED (Month, Day, Year)	32. BEGISTRAR'S SIG	SNATURE								
		OCT 2 3 1995	Julia Davids	ion Randal	4							

DHMH-18 Rev 1/89



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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

										50	330	4 1	
1 - STATE REGISTRAR	STATE OF M					EALTH AND DEATH	MENTAL	HYGIEN REG. NO.	E				
1. DECEDENT'S NAME (First, Middle, Last)								OF DEATH		WE . D	3. TIME OF DE	ATH	
CAROL	ANN		EMER	SON			OCT	. 19,	19	95 ^{YEAR}	10:30	P M	
4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last	birthday)	IF UNDER	1 YEAR	IF UNDER 24 HRS.	7. DATE O	OF BIRTH			IPLACE (State or	Foreign	
218-38-7999	1 🗆 M 2 💢 F	56	YRS.	MONTHS	DAYB	HOURS MIN.	Marret	8, 193	39	Popr	nsylvan:	ia	
9a. FACILITY NAME (If not institution, give str	eet and number)			9b. CITY	TOWN C	R LOCATION OF D	_	0, 10		UNTY OF D		Lu	
6908 Tennyson Ter RESIDENCE OF DECEMENT 108. STATE 10b. COUNTY Maryland Mont	race			Roc	kvil	le			Moi	ntgon	nery		
10e. STATE 10b. COUNTY			10c. CIT	Y, TOWN O	R LOCAT	ION			_		10d. INSIDE CI	TY	
Maryland Mont	gomery		Roc	kvil	10						LIMITS?		
	gomery		HOU	VATT		ZIP CODE	_		10a CI	TIZEN OF	WHAT COUNTRY		
10a. STREET AND NUMBER 6908 Tennyson Ter 11. Marital Status	raco					0855			17.				
11. MARITAL STATUS	12. WAS DECEDEN										States		
1 Never Married 2 Married 3X Widowed 4 Divorced		YES 2 X N		1	f yes, spi	ENDENT OF HISPA ledity Cuben, Mexica 2 NO Specifi	en, Puerto R	? (Specify Yea lican, etc.)	or No—		E American in k, White, etc. ////////////////////////////////////		
15. DECEDENT'S EDUC	ATION	16a, DE	CEDENT'S	USUAL O	CUPATIO	N	166	KIND OF BUS	SINESS/II	IDUSTRY	******		
(Specify only highest grade of		(GI	ve kind of a	work done o	during mo	at of working	1000	Time or bot	JII1E00711				
Elementary/Secondary (0-12)	College (1-4 or 5 +		sewi	fe				Own Ho	me				
Elementary/Secondary (0-12) 17. FATHER'S NAME (First, Middle, Last)		1100	JOUNI			18. MOTHER'S NA							
	n Do	nley				Ethel	AME (FIISI, N	nocie, Maiden	Sumame)	Blyl	O.T.		
	טט וו				7.						.er		
O I 198. INFORMANT S NAME (Type/FTITI)	19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, Stete, Zip Code)												
E. SCOLL EMETSON	E. Scott Emerson (Son) 5811 Hickory Rd, St. Leonard, MD 20685												
20b. METHOD OF DISPOSITION 1													
21. SIGNATURE OF PUNERAL SERVICE LICE	21. SIGNATURE OF TUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY												
1 1 R	Rapp Funeral Services, P.A. 933 Gist Ave, Silver Spring, MD 2												
1 204-0.6	w			9	33 G	ist Ave	, Sil	ver Sp	ring	, MD	20910)	
										Approxi	mate Between		
IMMEDIATE CAUSE (Final												nd Daeth	
disease or condition	Metast	atic Nor	nsmal	Ll Ce	11 (Carcinom	a of	Right	Lun	a	13 m	onths	
	DUE TO (OR AS A CONSEQUENCE OF):												
2	Sequentially list conditions b.												
Sequentially list conditions, If any, leading to immediate b. Due TO (OR AS A CONSEQUENCE OF):													
cause. Enter UNDERLYING													
CAUSE (Disease or Injury that initiated events	DUE TO	OR AS A CONSEC	DUENCE O	F):									
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Diseese or Injury that initiated events resulting in death) LAST													
	•												
PART II. Other significant condition	contributing to	death but not n	esulting	In the un	derlyln	ceuse given in	Part I.	24a. WAS AN PERFOR		241	AWAILABLE PRIC		
2								1 TYES 2			COMPLETION O		
Į I									,,		1 TYES 2	no.	
DID TOBACCO USE CONTR	IBUTE TO CA	USE OF DEA	TH Y	ES 🕡 I	NO F	UNCERTAL	ΝП				,		
DID TOBACCO USE CONTR													
EXAMINER?	EXAMINER? HOSPITAL: OTHER:												
27. MANNER OF DEATH	28a. DATE OF		28b. TIN		28c, INJ			(Specify)	N III III O	COLIDED			
	(Month, D		IN.	JURY	WO	RK?	200. DES	CHIDE HOW I	NJUNT U	CCORED			
2 Accident Investigation	20 - 21 405 0	E IN HIM ALL				ES 2 NO							
3 Suicide 6 Could not be	building,	F INJURY — At ho etc. (Specify)	me, term,	street, lact	ory, offic		City	ATION (Street in Town, State)	and Numb	er or Rural	Route Number,		
3 Suicide 6 Could not be determined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINED	_1												
29a. CERTIFIER 1X CERTIFYING PHYSIC	DAN: To the best of	my knowledge, de	ath occurr	red at the E	lme, date	and place, end du	a to the cau	se(a) and mai	nner aa a	tated.			
one) 2 MEDICAL EXAMINE	CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. Check only one) 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated.												
D 1010 6	MANUE.	1111				DO7:	_	•			20, 199		
						1 1 1 1 1	/ 4 1						

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

22. REGISTRAR'S SIGNATURE

Brown, M.D.

James A.

31. DATE FILED (Month, Disk, Year)

OCT 23 1995

9707 Medical Center Dr #300, Rockville, MD



20850

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumattic event, the medical examiner must be notified at once.

STATE	0F	MARYLAND	/ DEPARTMENT	OF HEALTH	AND	MENTAL	HYGIENE
		C	ERTIFICATE	OF DEAT	TH		REG. NO.

	1 - FOR STATE REGISTRAR	STATE OF MARYLA		TMENT OF H		MENTAL HYGIEN	E				
	DECEDENT'S NAME (First, Middle, Lest) Samu-	el Williams		2. DATE OF DEATH DATE OF DATE		YEAR	1:15 AM				
	4. SOCIAL SECURITY NUMBER 578-01-8904	5. SEX 8. AGE (III	yrs. last birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIFTH (Month, Day, Year) Sept. 22,1	8	BIRTHPLACE Country)	(State or Foreign		
TOR	9a. FACILITY NAME (If not institution, give str 8100 Connecticut	· ·	9	Chevy	or location of de Chase	EATH		of DEATH			
DIRECTOR	nesidence of Decedent 10a. STATE 10b. COUNTY Maryland	Montgomery	10c. CIT	y, town or local				L	NSIDE CITY IMITS? YES 2 X NO		
	10e. STREET AND NUMBER	Monegomery			ZIP CODE		10g. CITIZE	EN OF WHAT C			
FUNERAL	8100 Connecticut				20815		Unite	ed Stat	es		
ВУ	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 X Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA		If yes, sp		NIC ORIGIN? (Specify Yearn, Puerto Rican, etc.)	or No- 1	14. RACE — Am Black, White Specify:			
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12)			USUAL OCCUPATION WORK done during me tetired.)		16b. KIND OF BUS	SINESS/INDU	STRY			
MPL		3	Sal	esman		Mari	ne Di	esels			
00	17. FATHER'S NAME (First, Middle, Last)	-				ME (First, Middle, Maiden					
BE	Lafayette Brov	wne Eaton	105 MAILING	ADDRESS (Street		Thomas Pu					
2	John A. Berry								54		
	John A. Berry 8809 Potomac Station Lane, Potomac, MD 20854 20s. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of Commetter) 20c. LOCATION — City or Town, Sierta 20c. LOCATION — City										
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc., 7557 M00348 Wisconsin Avenue, Bethesda, MD 20814-3501										
CERTIFICATION	23. PART i. Enter the diseasea, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Finei disease or condition resulting in death) a. Cerebrovascular Accident DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):										
MEDICAL CE	PART II. Other algnificant conditions contributing to deeth but not resulting in the underlying cause given in Part I. Atherosclerosis 246. WAS AN AUTOPSY PERFORMED? 1 □ YES 2 🗓 NO										
CIAN:	DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL EXAMINER?			TH (Check only one,	UNCERTAI	N 🗆 📗					
BY PHYSICIAN:	1 VES 2 X NO 27. MANNER OF DEATH 1 X Netural 5 Pending Investigation	1 Inpetient 2 ER/Outp 28a. OATE OF INJURY (Month, Day, Year)	28b. Till	4 Nursing Hor IE OF 28c. IN JURY	Ne 5 XResidence PURY AT DRIK? YES 2 NO	6 Other (Specify) 26d. DESCRIBE HOW	y) HOW INJURY OCCURED				
	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28a. PLACE OF INJURY building, etc. (Spec	— Al home, farm,	street, fectory, offi	•	261. LOCATION (Street City or Town, State		or Rural Route N	lumber,		
COMPLETED	TOTAL OTHER	CIAN: To the best of my knowl R: On the basis of examination							manner as stated.		
TO BE	29b. SIGNATURE AND TITLE OF CERTIFIER Keyn G. N. Oct 30. NAME AND ADDRESS OF PERSON WHO	elon, m. l	ATH (ITEM 27) (Type	e, Print)	29c, LICENSE NU D23127	MBER		signed (Monti	23,1995		
	Kevin G. Nealon			sin Ave.	, Chevy	Chase, Mar	yland	20815	5		
	31. DATE FILED (Morth, Day, Year) OCT 24 1995 July Dayler Randle										

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DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARITLAND LANDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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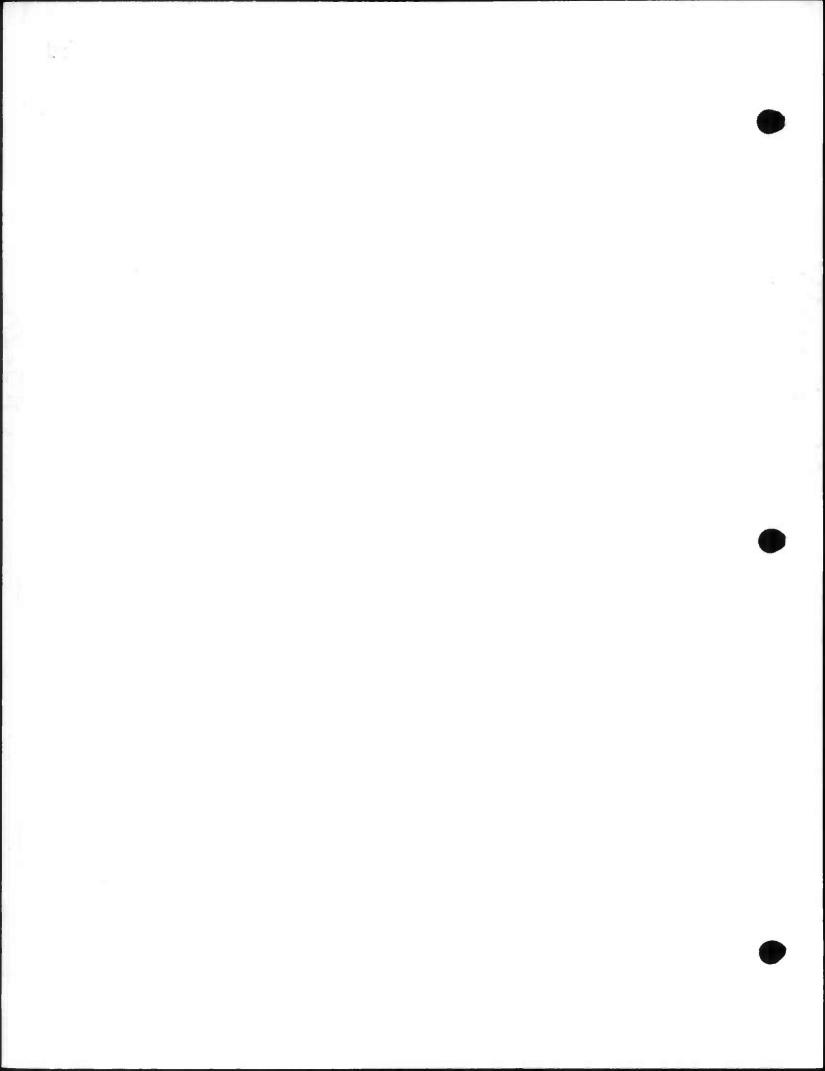
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certified at once.

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certified at once.

TO THE HOSPITAL DR ATTENDING PHYSICIAN. The medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

FOR 1 - STATE REGISTRAR	STATE OF MARYLA	ND / DEPARTM			MENTAL HYGIEN	E	
1. DECEDENT'S NAME (First, Middle, Last)	3. TIME OF DEATH						
Robert	Henry E	ager, Sr			2. DATE OF DEATH MONTH October 25		AR
4. SOCIAL SECURITY NUMBER			UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH		HRTHPLACE (State or Foreign
033-18-1958	1 🔀 M 2 🗌 F	69 YRS. MOI	NTHS DAYS	HOURS MIN.	(Month, Day, Year)	C	ountry) assachusetts
9e. FACILITY NAME (If not institution, give street	et and number)	96	CITY, TOWN C	R LOCATION OF DE		9c. COUNTY (
20073 Placid Lake	Terrace		Germa	ntown		Mont	tgomery
10e. STATE 10b. COUNTY		10c. CITY, 10	OWN OR LOCAT	ION			10d. INSIDE CITY
Maryland Mont	gomery	Gen	rmantov	7N ZIP CODE			1 ☐ YES 2 🖾 NO OF WHAT COUNTRY?
20073 Placid Lak	e Terrace		100				
	2. WAS DECEDENT EVER IN	U.S. ARMED	13. WAS DEC	20874	IIC ORIGIN? (Specify Yes		ed States
1 Never Married 2 K Married	FORCES? 1 X YES	2 NO	It yes, sp	cify Cuban, Mexica 2 X NO Specify	n, Puerto Ricen, etc.)	1	RACE — American Indian, Black, White, etc.
3 Widowed 4 Divorced	1943 - 19		' ' ' ' '	2 DC NO Specin		3	Specify: White
15. DECEDENT'S EOUCAT (Specify only highest grade co	TION (moleted)	16a. DECEDENT'S USU (Give kind of work	JAL OCCUPATIO	N et of working	16b. KIND OF BUS	INESS/INDUSTR	
	College (1-4 or 5+)	life. Do NOT use rel	tired.)	or working			
	1	Municipal	Bond	Trader	Ban	king	
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Middle, Malden	Surname)	
	mpson Eager				Grace	Wright	
19e. INFORMANT'S NAME (Type/Print)		19b. MAILING ADD	DRESS (Street a	nd Number or Rural F	Soute Number, City or Town	n, State, Zip Code)
Janet Eager		20073 P1	acid L	ake Terr	ace, Germa	ntown,	MD. 20874
20a. METHOD OF DISPOSITION 1 □ Burlal 2 ☒ Cremation 3 □ Remove		PLACE AND DATE OF DI		ne of	DATE 20c. LO	CATION — City o	or Town, State
4 Donation 8 Other (Specify)	Me1	ropolitar	Crema		10/25 Ale	xandri	a, Virginia
21. SIGNATURE OF FUNERAL SERVICE LICEN	ISEE O'C	10	22. NAME AN	D ADDRESS OF FAC	DeVol	Funeral	L Home
Mehm	KD GU	May	10 E.D	eer Park	Dr., Gait	hersbur	g, MD. 20877
23. PART i. Enter the diseases, or con- ehock, or heart failure. Lis	nplicetions that caused it only one ceuse on ea	the deeth. Do not e ch line.	enter the mo	ie of dying, such	as cerdiac or reepi	ratory arrest,	Approximata interval Between
IMMEDIATE CAUSE (Finsi							Onset and Death
disease or condition resulting in death) s	Metastatic		Carci	noma			6 weeks
	DUE TO (OR AS A	CONSEQUENCE OF):					
Sequentially list conditions, b.	DUE 70 (DD 40 4	2010201212					
if sny, leading to immediate cause. Enter UNDERLYING	DOE TO (OH AS A	CONSEQUENCE OF):					i
CAUSE (Disease or injury that initiated events	DUE TO (OR AS A	CONSEQUENCE OF:					
resulting in desth) LAST		THE WASHINGTON					į i
d							
PART ii. Other significent conditions of	contributing to death bu	t not resulting in th	ne underlying	ceuse given in	Pert i. 24s. WAS AN PERFOR		24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO
					1 YES 2		COMPLETION OF CAUSE OF GEATH?
							1 YES 2 NO
DID TOBACCO USE CONTRIB	BUTE TO CAUSE OF	DEATH YES	□ NO □	UNCERTAIN	I 🛛		
25. WAS CASE REFERRED TO MEDICAL EXAMINER?	OSPITAL:	8. PLACE OF DEATH (C					
1 ☐ YES 2 🔀 NO 1	☐ Inpatient 2 ☐ ER/Outpa		HER: Nursing Home	5 M Residence	8 Other (Specify)		
27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJU	IRY AT	28d. DESCRIBE HOW IN	JURY OCCURE	0
1 Natural 5 Pending 2 Accident Investigation				ES 2 NO			
3 Suicide 8 Could not be 4 Homicide datarmined	28e. PLACE OF INJURY - building, etc. (Specif	- At home, term, atreet	t, factory, office		281, LOCATION (Street a City or Town, State)	nd Number or Ru	rel Route Number,
29a. CERTIFIER 1 CERTIFYING PHYSICIA	N: To the heat of my live of	des de de			ren continue data con		
(Check only one) 2 MEDICAL EXAMINER:							se(s) and manner as stated.
29b. SIGNATURE AND THILE OF CERTIFIER				29c. LICENSE NUM			
Henre	a. SJ	Ark in	0				NED (Month, Day, Year)
30. NAME AND ADDRESS OF PERSON WHO C	COMPLETED CAUSE OF DEA	TH (ITEM 27) (Type, Print	1)	D 43083)	OGEOI	ber 25, 1995
George A. Sotos, M				ive. #30	O. Rockwil	le. MD	20850
31. DATE FILED (Month, Day, Year)	32 REGISTRAR'S SIGNA	TURE	JUL DI	_, , , , , , , ,	o, Rockvii	ie, fill	20030
OCT 27 1995 July	Davidson Rand	all					



1		-	STATE REGISTR	1
	1.	D	ECEDENT'S	

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CEF	TIFIC	TE OF	DEATH	REG. NO	J.	
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH	DAY YE	3. TIME OF DEATH
	OPAL LOI	RETTA	FOSTER				OCTOBER		
	4. SOCIAL SECURITY NUMBER		6. AGE (In yrs. last bi	77	NDER 1 YEAR	IF UNDER 24 HRS.	7 DATE OF BUILDIN		
	233-98-5096 9e. FACILITY NAME (If not inelitation, give	1 🗆 M 2 💥 F	50	YRS. MON		HOURS MIN.	JULY 23,		BIRTHPLACE (State or Foreign Country) VA.
DIRECTOR	SACRED HEART HOS			- 1	CUMBEI	RLAND	EATN	Sc. COUNTY ALLE	GANY
EC	10d. INSIDE CITY LIMITS?								
FUNERAL	RT. 1 BOX 145					1. ZIP CODE 26764			SA
ВУ	11. MARITAL STATUS 1 XX Rever Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT FORCES? 1 [IF YES, GIVE WA	YES 2 X NO	D	If yes, s		NIC ORIGIN? (Specify Van, Puerto Ricen, etc.) by:		RACE — American Indian, Black, While, etc. Specify: WHITE
ED	15. DECEDENT'S ED (Specify only highest grad	UCATION	16a. DECEI	DENT'S USU	AL OCCUPATI	ON pst of working	16b, KIND OF B	USINESS/INDUST	ray
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do	NOT use ret	ORKED	ost or working	N/A	4	
MC	17. FATNER'S NAME (First, Middle, Leet)					16 MOTHER'S NA	ME (First, Middle, Maide		
BE C	STANLEY DIXON	FOSTER				MARGU		RGINIA	GENNOY
TO B	190. INFORMANT'S NAME (Type/Print) GERALDINE SHINGI	FTON			RESS (Street IOKE A		Route Number, City or To AKLAND, MI		(a)
	20e. METNOD OF DISPOSITION	EION							
	1 X Buriel 2 Cremation 3 Re 4 Donation 5 Other (Specify)	moval from State	cemetery, crema					RRA ALT	A, W. VA.
	21. SIGNATURE OF UNETAL SERVICE I	Dunt	M001		22, NAME A	ND ADDRESS OF FA	I I	2.0. BOX	
	23. PART I. Enter the diseases, or	complications that							
	ahock, or heart failure IMMEDIATE CAUSE (Final disease or condition	. List only one caus	e on aach Ilna.		^				Interval Batween Onaat and Death
	resulting in death)	. Houte	or as a conseque	NCE OF):					3 minutes
NO	Sequantially list conditions,	Acute	Aspira	tion	WI	th Sep	osis		1-2 hours
CERTIFICATION	if any, leading to immediata cause. Enter UNDERLYING	DUE TO (C	DR AS A CONSEQUE	NCE OF):					
LIFIC	CAUSE (Disease or Injury that initiated events	DUE TO (OR AS A CONSEQUE	NCE OF):					
ER	resulting in dasth) LAST	d							
	PART II. Other eignificant condition	- ,	1 .			g cause given in	Part I. 24a. WAS A	N AUTOPSY ORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
MEDICAL	Toxic Megacoloi	2 with te	cal imp	action	n		1 (T YES	2 - NO	COMPLETION OF CAUSE OF DEATH?
ME	Mental Metard	ation with	h inabilit	4 to	cooper	ate with T	realpent.		1 TYES 2 NO
AN:	DID TOBACCO USE CON	TRIBUTE TO CAL					NM		
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPITAL:		OT	HER:				
HXS	27. MANNER OF DEATH	28s. DATE OF II	NJURY 2	8b. TIME OF	28c. IN	JURY AT	6 Other (Specify) 28d. DESCRIBE HOW	INJURY OCCUR	ED
ВУ Р	1 Netural 5 Pending 2 Accident Investigation	(Month, De)	y, Year)	INJURY		ORK? YES 2 NO			
	3 Suicide 8 Could not be 4 Nomicide determined	28e. PLACE OF	INJURY — At home rtc. (Specify)	, farm, atree	, lectory, offi	De	281. LOCATION (Stree City or Yown, Stat		Rural Route Number,
JE	290. CERTIFIER 1 CERTIFYING PHY	SICIAN: To the best of n	ny knowledge, death	occurred at	the time, dat	e end place, end du	to the cause(s) end m	nenner es stated.	
COMPLETED	enel								euse(s) end menner es stated.
BE C	29b. SIGNATURE AND TITLE OF CERTIF	ER O	*	1		29c. LICENSE NU	MBER	29d. DATE SI	IGNED (Month, Day, Year)
TO B	Warn	165	PX	9 ,	7	D114	43	Octobe	129.95
-	30. NAME AND ADDRESS OF PERSON W		DEATH (ITEM 2	01		sive P.	mh. /a.	1 110	0.5
	31. DATE FILED (MODIF) Pay, year)	32. REGISTRAR	'S SIGNATURE	Set	on D	ive W	imberland	7,19	21502
	00 31 9	195	Le Mar Ros	dall.					

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retained by the hospital or attending physician. 5 should be detached for use as the burial-transit after death. Page 6 may be death certificate be executed

BALTIMORE, MARYLAND 21215-0020

76 notified å must examiner medical the event,

DIRECTOR

FUNERAL

BY

COMPLETED

BE

2

CERTIFICATION

MEDICAL

PHYSICIAN:

BY

COMPLETED

BE

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EXAMINER?

2 Accident

3 Suicide

1 YES 2 NO

27. MANNER OF DEATH

permit. Pages 1, 2, 3

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cate	state	Item
ertifi	the	6
his C	after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
ter th	ath v	nart
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BOX 68760

P.O.

DIVISION OF VITAL RECORDS,

Me

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HOSPITAL OR ATTENDING PHYSICIAN:

DIRECTOR: / Hem

FUNERAL (within 72 h 2

TO THE HOSPITA
TO THE FUNERAL
DE FIED WITHIN 72
IMPORTANT: 11

95 33651 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last, 2. DATE OF DEATH 3. TIME OF DEATH 1945 DPC Frederick Junior Octobe 17 Fadeley 4. SOCIAL SECURITY NUMBER 5. SEX IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign 07-03-1918 220-01-6132 1 M 2 - F 77 Se. FACILITY NAME (If not institution, give alreet end number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Harford Memorial Hospital Havre de Grace Harford RESIDENCE OF DECEDENT 10a, STATE 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY MD Harford Havre de Grace 1 X YES 2 | NO 10s. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 708 Lewis Street 21078 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-14. RACE - American Indian, Black, White, etc. 1 Never Married 2 Married If yes, specify Cuban, Mexican, Puerto Rican, atc.) 1 YES 2 NO Specify: 3 Widowed 4 Divorced Specify: White 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Elementary/Secondary (0-12) College (1-4 or 5+) 11 Sheet Metal Worker Aircraft Manufacture 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) Robert Frederick Fadeley, Sr. Myrtle Fulton 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. G. Heidi Fadeley 708 Lewis Street, Havre de Grace, MD 26e. METHOD OF DISPOSITION
1 X Buriel 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State Metery, cremetory of other place)
Angel Hill Cemetery 4 Donation 6 Other (Specify) 10/20 Havre de Grace, MD 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Mitchell-Smith Funeral Home, P.A. Havre de Grace, MD 21078-3197
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata shock, or heart feliure. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Final **Onset and Death** disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): CHROLIK Sequentially list conditions. DUE TO (OR AS A CONSEDUENCE OF) if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa DUE TO (OR AS A CONSEQUENCE OF) resulting in death) LAST PART II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part i. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PERFORMED? INTARCTION 1 TES VES DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN

25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)

flant 2 - ER/Outpatient 3 - DOA 28a. DATE OF INJURY 26b. TIME OF

OTHER:
4 | Nursing Home 6 | Residence 6 | Other (Specify) 26d. DESCRIBE HOW INJURY OCCURED

28c. INJURY AT WORK? 1 YES 2 NO 26e. PLACE OF INJURY — At home, farm, atreet, fectory, office building, etc. (Specify)

281. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29e. CERTIFIER (Check only one)

CERTIFYIND PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 MEDICAL EXAMINER: On the 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER

4580

29d. DATE SIGNED (Month, Day, Year) 10

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) PUDO

31. DATE FILED (Month, Day, Year) OCT 1 8 1995

Investigation

6 Could not be

DHMH-16 Rev 1/89

	Amended :	#18,	11/1	/95,	JW,	Montgomery	County				
1	FOR STATE REGISTRAR			STATE	OF M	ARYLAND / DEPAR CERTIF	TMENT OF H		MENTAL HYGI REG.		
	1. DECEDENT'S NAME	(First, Midd	lie, Last)						2. DATE OF DEATH		
	Eileen		Mary		Fi	tzgerald			October	25	19
	4. SOCIAL SECURITY I	NUMBER		5. SEX		8. AGE (In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH		

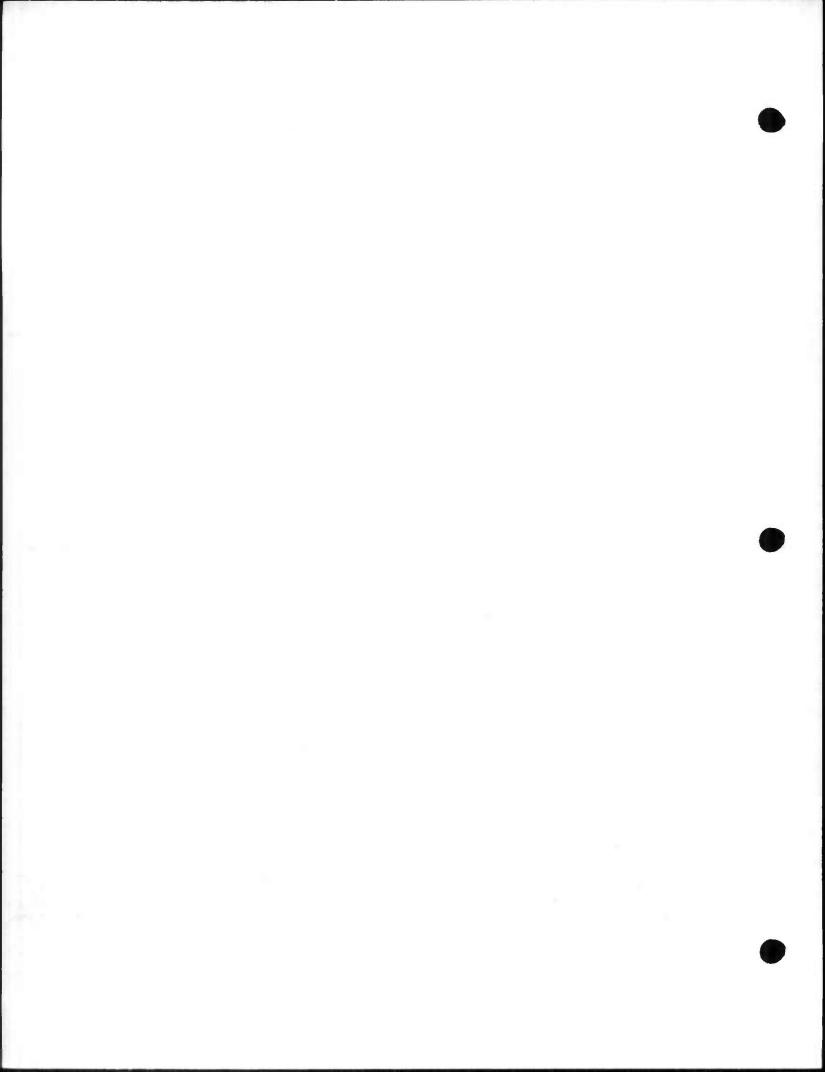
	Eileen Mar		gerald			October 2	DAY 1.	YEAR	. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER			IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH		995	ACE (State or Foreign
	213-48-0416	1 M 2 K F		MONTHS DAYS	HOURS MIN,	(Month, Day, Year) Sept. 5,	1902	Country)	achusetts
	De. FACILITY NAME (If not institution, give	street and number)		9b. CITY, TOWN	OR LOCATION OF DE			TY OF DEA	тн
DIRECTOR	Holy Cross Hospi	tal		Silver	Spring		Mon	tgome	ery
E	10e. STATE 10b. COUN	TY	10c. CITY	TOWN OR LOCA	TION			10	Od. INSIDE CITY
		ntgomery	Si	lver Sp			1	☐ YES 2 NO	
FUNERAL	9412 Thornhill F	Road		10	20901	10g. CITIZEN OF WHAT COUNTRY? USA			
B	11. MARITAL STATUS 1 Never Married 2 Married 3 X Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 YE IF YES, GIVE WAR OR	S 2 NO	13. WAS DEC	14. RACE Black, V Specify:	RACE — American Indian, Black, White, stc. Specify: White			
LETED	15. DECEDENT'S ED (Specify only highest grad Elementary/Secondary (0-12)		life. Do NOT use	ork done during me retired.)	ON ost of working	16b. KIND OF B		JSTRY	
COMPLET	12		Homema	ker		Own 1			
BE CO	James T. Duffy					ME (First, Middle, Maide May-Bolen		ie Ma	y Boler
0	19a. INFORMANT'S NAME (Type/Print)	E: h			and Number or Rural R	loute Number, City or To	wn, State, Zip	Code)	
	Sister Eileen T.					, Columbia		2104	
	1 💢 Buriel 2 🗆 Cremation 3 🗆 Res		ob. PLACE AND DATE O emetery, crematory of oth Gate of He			DATE 20c. L	ocation – c Silver	Spri	ing. MD
	21. SIGNATURE OF FUNERAL SERVICE L		Sacc of He	22. NAME A	ND ADDRESS OF FAC	CILITY			
	* Steven()	Lund				llins Fun y Blvd.W.			
PHYSICIAN: MEDICAL CERTIFICATION	IMMEDIATE CAUSE (Final disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated eventa resulting in death) LAST PART II. Other significant condition of the condition of	DUE TO (OR AS C. DUE TO (OR AS d. My oc. DISCHOOL TRIBUTE TO CAUSE HOSPITAL: 1 X Inputtert 2 = ER/O 280. DATE OF INJUR (Month, Day, Year)	S A CONSEQUENCE OF S A CONSEQUENCE OF S A CONSEQUENCE OF S A CONSEQUENCE OF S A CONSEQUENCE OF C DEATH YE: 28. PLACE OF DEATH Lutperlent 3 DOA Y 28b. TIME	this is the state of the state	g cause given in	PERFC 1 PES		A C O O 1	Interval Between Onset and Death Pere Autopsy Findings Walladle Prior to owneterion of Cause F Death? YES 2 NO
) BY	2 Accident Investigation 3 Suicide 6 Could not be	28e. PLACE OF INJU	RY — At home, farm, s			281. LOCATION (Stree		or Aural Aou	ite Number,
	4 Homicide determined	building, etc. (S				City or Town, Stel	0,		
COMPLETED	TOTAL OTHER	SICIAN: To the best of my kn							nd manner as stated.
E E	296. SIGNATURE AND TITLE OF CERTIFIC ROBERT PAGES	Elmen 1	N		29c, LICENSE NUN		29d. DATE	SIGNED (A	fonth, Day, Year)
2	30. NAME AND ADDRESS OF PERSON W. Robert F. Mus.	who completed cause of selman, MD	DEATH (ITEM 27) (Type,	Print)	Hoset S	ilver Spring	an me	20	710
	31. DATE FILED (Month, Day, Year) OCT 2 7 1995	Julia Dewalson	RANDALL						

DHMH-18 Rev 1/89

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DIVISION
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1 - STATE REGISTRAR	STATE OF MA	RYLAND / DI CER	EPARTIN ITIFIC	MENT OF H	EALTH AND DEATH		IYGIENE REG. NO.		
1. DECEDENT'S NAME (First, Middle, Last)		Cana	. 0			2. DATE OF MONTH	DEATH	YEAR	3. TIME OF DEATH
4. SOCIAL SECURITY NUMBER	1	AGE (In yrs. last bir	their IF	UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF	Pinth	9)	THE N
299-38-7217	1)XXM 2 □ F		YRS. MO	NTHS DAYS	HOURS MIN.	June 1	ly; Year)	145	Ohio
9a. FACILITY NAME (If not institution, give					R LOCATION OF DI	EATH		9c. COUNTY OF	DEATH
1309 Leister Dr. RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT Maryland Monte	ive		5	Silver	Spring			Montgo	mery
10a. STATE 10b. COUNT	ry	10	Dc. CITY. TO	OWN OR LOCATI	ON				10d. INSIDE CITY
Maryland Mont	gomery	1		er Spr					LIMITS?
	gomery		311(ZIP CODE				1 TES 2 X NO
1309 Leister Dr	ivo			350	20904				WHAT COUNTRY?
1309 Leister Dr. 11. MARITAL STATUS	12. WAS DECEDENT EV	VED IN 11 0 ADMEN							States
3 Widowed 4 Divorced	FORCES? 1	YES 2 NO	,		ENDENT OF HISPAI city Cuben, Mexice 2 (X) NO Specifi	in, Puerto Ricar		Spo	CE — American Indian, ack, Whita, atc. acity: White
15. DECEDENT'S EDI (Specify only highest grad Elementary/Secondary (0-12) 12 17. FATHER'S NAME (First, Middle, Last)	JCATION			JAL OCCUPATIO		16b. K#N	ID OF BUSIN	ESS/INDUSTRY	MITTOC
(Specify only highest grad	College (1-4 or 5 +)	(Give k	ind of work NOT use re	done during mos tired.)	t of working	111-23-3		errine extin	
12		Assist	tant	Servic	e Manage	er Car	Deal	er	
17. FATHER'S NAME (First, Middle, Lest)					16. MOTHER'S NA				
Melvin Fink					Eleano				
19a. INFORMANT'S NAME (Type/Print)		19b, M	AILING AD	DRESS (Street ar	d Number or Rural I			State 7in Codel	
Sherri L. Fir	nk				ll Way,			rg, MD	20877
20a. METHOD OF DISPOSITION 1 ☐ Burial 2 (¥ Cremation 3 ☐ Ran	noval from State	20b. PLACE AND			ne of	DATE	20c. LOCAT	TION — City or	Town, State
4 Donation 6 Other (Specify)		Chesape	eake	Cremat	ory	10-22	Belts	sville,	Maryland
21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE	7	-		ADDRESS OF FA	CILITY			
- Cleen	K/ K	aso			uneral (st Avenu				MD 20910
IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	DUE TO (OR DUE TO (OR c.	AS A CONSEQUER	NCE OF):	end	e N	part	De	202 32	Onset and Death
	d								
PART ii. Other significant condition	ns contributing to dea	ath but not resu	Iting In th	ne underlying	cause given in	Part I. 24s	. WAS AN AU		Ib. WERE AUTOPSY FINDINGS
						1[PERFORME YES 2X()		AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
DID TOBACCO USE CONT	DIDLITE TO CALLS	E OF DEATH	VEC	NO II	LINICEDTAIN				1 TES 2XXNO
25. WAS CASE REFERRED TO MEDICAL	T CAUS			Check only one)	UNCERTAIN	и 🗆 📗			
EXAMINER?	HOSPITAL:		01	HER:	\ /				
YES 2 NO	1 Inpetient 2 ER			Nursing Home		6 Other (Sp			
1 Natural 5 Pending 2 Accident Investigation	26s. DATE OF INJE (Month, Day, Y		b. TIME OF INJURY	WOR	RY AT K? ES 2 NO	28d. DESCRIE	BE HOW INJU	JRY OCCURED	
3 Suicide 6 Could not be 4 Homicide detarmined	28e. PLACE OF IN. butlding, etc.	JURY — At home, (Specify)	farm, street	t, factory, offica		281. LOCATIO City or To	N (Street and wn, State)	Number or Rural	l Route Number,
29a. CERTIFIER (Check only one) 1 CERTIFYING PHYS	ICIAN: To the best of my	knowledge, death o	occurred at	the time, data a	and place, and due	to the cause(a)) and manner place, and d	r as stated.	(a) and manner as stated.
296. SIGNATURE AND LITLE OF CERTIFIE					29c. LICENSE NUN				D (Month, Day, Year)
1 20x C	value /	4 00		1	DOS	274	6) h	t 19.51
30. NAME AND ADDRESS OF PERSON WE	O COMPLETED CAUSE O	F DEATH (ITEM 27)	(Type Prin	0		, ,	9	0-	1 7 7 0
20 har 1	an ber				Sco	2511	7	Ace	Bettes
31. DATE FILED (Month, Day, Year) OCT 23 1995	32. REGISTRAR'S	SIGNATURE	,						
20. 20. 1333	Thurs are all	est Maria							DHMH-16 Rev 1/6



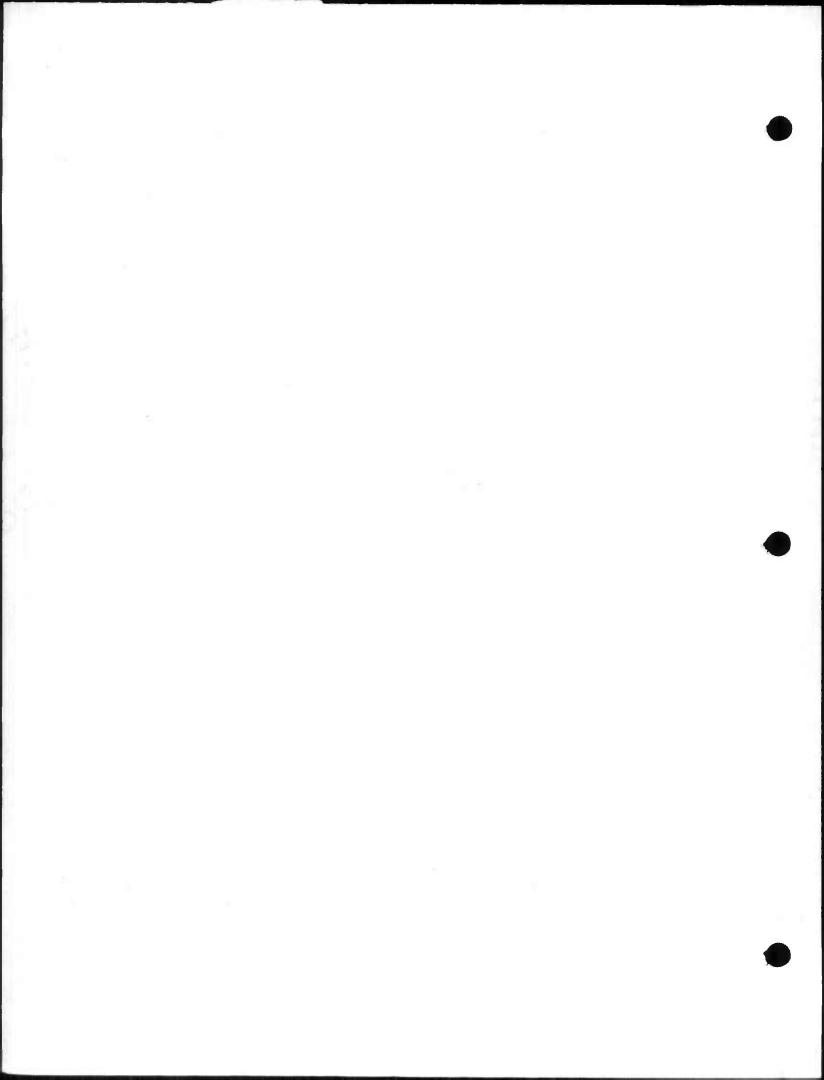
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the law interest of the control of the control of the attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	1 - STATE REGISTRAR	STATE OF N	/ MARYLAND / CE				DEAT			YGIEN EG. NO.	E		
	1. DECEDENT'S NAME (First, Middle, Last)			-11111	- CALL	- 01	DEA		2. DATE OF	DEATH			3. TIME OF DEATH
	Jorge Tom	as	Felices						Octobe	er 2		1995	3:01 A M
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last	t birthday)	IF UNDER		IF UNDER		7. DATE OF E	BIRTH			PLACE (State or Foreign
	581-01-9527	1 🔀 M 2 🗌 F	77	YRS.	MONTHS	DAYS	HOURS	MIN.	Dec.	[2,]	1917	Pu	erto Rico
	9a. FACILITY NAME (If not institution, give s	treet and number)			9b. CITY	, TOWH C	R LOCATIO	ON OF DE	ATH		9c. COU	INTY OF DE	ATH
8	Holy Cross Hosp	ital			S	ilve	r Sp	ring			Mo	ntgom	ery
티	RESIDENCE OF DECEDENT 10a, STATE 10b, COUNT	·		I too CIT	Y, TOWN (OR LOCAT	101						10.4 10.000 0.000
DIRECTOR		ntgomery			ilve								10d. INSIDE CITY LIMITS?
	10e. STREET AND NUMBER	2708011027					ZIP CODE	F			10a CIT		1 X YES 2 NO
FUNERAL	2509 Hayden Dri	ve						209	02		104. 01.	US	
5	11, MARITAL STATUS		T EVER IN U.S. ARI		13.	WAS DEC	ENDENT O	F HISPAN	IIC ORIGIN? (S	pecify Yes	or No-	14, RACE Black.	- American Indian, White, atc.
ВУ	1 Never Married 2 X Married 3 Widowed 4 Divorced	IF YES, GIVE W					2 NO	Specify	<i>r</i> :	1, 210.7		Specify	<i>t</i> :
	15. DECEDENT'S EDU	CATION	16a DEC	CEDENT'S	IISHAL O	CCUPATIO		rto.	Rican	D OF BUI	SINESS/IN	DUSTRY	White
COMPLETED	(Specify only highest grade Elementary/Secondary (0-12)	completed)	(Gi	Do NOT u	work done	during mo	st of working	gof				istan	t to
7	Comencary/Secondary (0-12)	College (1-4 or 5 or 5 or 5 or 5 or 5 or 5 or 5 or	' I the	UII	ice (OI P	uerton,	2	Con	gres	sman	of P	uerto Rico
S	17. FATHER'S NAME (First, Middle, Last)		INIC	O III	nas.	HIHE			ME (First, Middl	le, Maiden	Surname)		
BE C	Jorge Felices						Ros	sa J	ulia P	ietr	anto	ni	3.4
10 8	19a. INFORMANT'S NAME (Type/Print)	`							Route Number, C				1.7
۲	Amy Denton Feli	ces	2.	509	Hayd	en D	rive	, Si	lver S	prin	g, M	D 20	902
	20a. METHOD OF DISPOSITION 1 Buriel 2 Cremation 3 Rem	oval from State	20b. PLACE A					10	DATE	20c. LO		City or Tow	
	4 Donation 5 Other (Specify)	CENCEE	Metrop	oolit			D ADDRES		/26/95	Ale	exano	dria,	VA
	MA I)	11							Fun	eral	Home	, Inc.
	Mathi	Tus.	2/_										MD 20901
	23. PART i. Enter the diseeses, or shock, or heart failure.	complications the	t coused the deuse on each line	ath. Do	not enter	the mo	de of dy	ing, suci	h ea cardiac	or reapi	ratory as	rreat,	Approximate interval Batween
	IMMEDIATE CAUSE (Final												Onsat and Death
	disease or condition resulting in death)		Myocar			arct	ion						10 Days
_ [OR AS A CONSECUTION ATT			roci	c						Years
CERTIFICATION	Sequentially list conditions,	D	(OR AS A CONSEC			1031	5						Tears
SAT	if any, leading to immediate cause. Enter UNDERLYING	6											
Ĕ	CAUSE (Disease or Injury that initiated evanta	DUE TO	(OR AS A CONSEC	DUENCE O	F):								
FI	resulting in death) LAST	d											
	PART il. Other significant condition	ns contributing to	death but not re	aauiting	in tha u	nderivino	causa d	aiven in	Part i. 24	. WAS AN	AUTOPSY	24b.	WERE AUTOPSY FINDINGS
MEDICAL	Chronic and			_						PERFOR			AWAILABLE PRIOR TO COMPLETION OF CAUSE
	Upper Gastro				ort	-ha	9.0		- ''	YES 2	K NO		OF DEATH?
2 2	DID TOBACCO USE CONT		USE OF DEA				_	ERTAIN	V K				1 163 2 100
Ž	25. WAS CASE REFERRED TO MEDICAL EXAMINER?			E OF DEA									
Sic	1 VES 2 XND	HOSPITAL:	ER/Outpatient 3	□ DOA	OTHE 4 Nu		a 5 🗆 Re	aldence	8 Other (Sp	pecify)			
PHYSICIAN:	27, MANNER OF DEATH	28a. DATE OF (Month, D		28b. TIN	IE OF	28c. INJ WO	URY AT		28d. DESCRI	BE HOW I	NJURY O	CCURED	
BY	1 Natural 5 Pending 2 Accident investigation				М		rES 2	NO					
	3 Suicida 8 Could not be 4 Homicide detarmined	28a. PLACE C building,	of INJURY — At horate. (Specify)	ma, farm,	street, fac	tory, offic			28f, LOCATIO City or To	N (Street : owri, Stete)	and Numbe	or Rural R	oute Number,
E													
4	country of	ICIAN: To the best of	/ /										
COMPLETED	2 MEDICAL EXAMIN		xamination and/or i	investigation	on, in my	opinion, d	eath occur	red at the	time, data and	l place, an	d due to t	the cause(a)	and manner ea steted.
BE	290. SIGNATURE AND TITLE OF CERTIFIE	0	- //				29c. LICI	ENSE NUA	MBER	-	29d. DA	TE SIGNED	(Month, Day Year)
6		10 COMP 11 11 11 11 11 11 11 11 11 11 11 11 11	ey					ノ	2000		P /	0/.	7190,
	30. HAME AND ADDRESS OF PERSON, WI	SULTAN	SE OF DEATH (ITE	и 27) (Туре С)	Print)	ver	. (orii	MI	d	110	6440	4 B Car
	31. DATE FILED (Month, Day, Year)	32. 815/578	IR'S SIGNATURE		211		3	1	1		Me	ישעריי	7 000
	OCT 25 1995	10 1.	whom Rando	. //									V
	001 40 1995	1)	AND A LINGS	LAV.									



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with. Fhours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlat-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlat, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH								3. TIME OF DEATH					
	RALPH HUGHES	GRAHA	M				10	70		95 2020 M				
	4. SOCIAL SECURITY NUMB	ER	5. SEX	6. AGE (In yrs. lest	birthday)	IF UNDER	1 YEAR	IF UNDER	t 24 HRS.	7. DATE OF E	HTRE	7	8. BIRTH	IPLACE (State or Foreign
	215-18-475	1 M 2 □ F 75		YRS.	MONTHS	DAYS	HOURS	MIN.	(Month, Da	ly, Year)		Counti	(y)	
	9s. FACILITY NAME (If not in:	/-	,	9b. CITY,	b. CITY, TOWN OR LOCATION OF DEATH Sec. 6					9c. COU	Maryland			
FUNERAL DIRECTOR	4404 TYASKIN		TYAS					WICC	MICC)				
E E	10e. STATE	10c. CIT	Y, TOWN O	R LOCAT	ION						10d. INSIDE CITY			
E	Maryland	Wic	omico		Tv	aski	1							LIMITS?
7	10e. STREET AND NUMBER					40111		ZIP COD	E			10a, CITI	ZEN OF V	WHAT COUNTRY?
8	4404 Tyask	in Wha	rf Rd				-	218	65			111.514	USA	
ž	11. MARITAL STATUS	III WIIG	12. WAS DECEDEN	T EVER IN U.S. ARI	4ED	13. 1	WAS OF			IC ORIGIN? (S	nacify Yes	or No		
I	1 Never Married 2 🔀		FORCES? 1 IF YES, GIVE W	XYES 2 N	0	1 1	yes, sp	ecify Cubs	ın, Mexica	n, Puerto Ricar	i, etc.)	01.110		E — American Indian, k, White, etc.
B	3 Widowed 4 Divo	rced		rmy			_ TES	2 MO	Specin	<i>.</i>			Spec	WHITE
COMPLETED	15. DECI								16b. KIN	D OF BUS	INESS/IND	USTRY	WILLIAM	
	Elementary/Secondary (0		College (t-4 or 5+	Min	Do NOT us	se retired.)	uring mo	St OF WORK	ng					
4	8		0	Cu	stod	ial				Во	ard	of E	duca	tion
8	17. FATHER'S NAME (First, Mi	iddle, Last)						18. MOT	HER'S NA	ME (First, Middl	e, Maiden	Sumame)		
BE (Alvin P.		m					Н	elen	Ander	son			
2	19a, INFORMANT'S NAME (7)			19b	MAILING	ADDRESS	(Street s	nd Numbe	r or Rural I	Route Number, C	ity or Town	n, State, Zip	Code)	
F	Pearl Grah	am			P.O.	Box	32,	Tya	skin	, MD 2	1865			
	20s. METHOO OF DISPOSITI 1 ☐ Buriel 2 🏋 Crematio		oval from State	20b. PLACE A			TION/No	me of				CATION —		
	4 Donation 8 Other	(Specify)		Salis	bury	Crei					Sal	isbu	ry,	MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAM							NAME AND ADDRESS OF FACILITY LESSICK Funeral Home							
	* malle	. 5	MAIN	sulle								n 01	0.17	
	23. PART I. Enter the di	seasea, or c	omplications the	caused the dea	ith. Do r	not enter	the mo	de of dv	Ing. suc	Bivalv	or readi	ratory an	O 14	Approximate
	anock, or he iMMEDIATE CAUSE (Fin disease or condition resulting in deeth)	iei	ARTERIO		C CA	RDIO	VASC	ULAR	DIS	SEASE				interval Between Onset and Death
ATION	Sequentially list condition of the sequential sequential sequence is sequentially list to the sequential seque	diete		(OR AS A CONSEC										
CERTIFICATION	CAUSE (Disease or inju that initiated eventa reaulting in death) LAS		DUE TO	(OR AS A CONSEC	UENCE O	F):								
MEDICAL C	PART II. Other significa	nt condition	s contributing to	death but not n	sulting	in the un	derlyin	g ceuse :	given in		PERFOR	MED?	24b	. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE
AEC										_] ''		(B) 110		OF DEATH?
	DID TOBACCO	O USE O	CONTRIBUTE	TO CAUS	E OF	DEAT	НУ	ES I	1 NC					
N.	25. WAS CASE REFERRED TO	- V								eck only one)				
Sic	EXAMINER?		HOSPITAL: 1 Inpatient 2	ER/Outpatient 3	□ DOA	OTHER 4 Num		• 5 X R	ealdence	8 Other (Sp	ecify)			
PHYSICIAN:	27, MANNER OF DEATH		28a. DATE OF (Month, Da	INJURY	28b. TIM	E OF	28c. INJ	URY AT		28d. OESCRII		NJURY OC	CURED	
ВУ Р		Pending Investigation	(Month, Da	ay, rear)	IIAT	M		RK? YES 2	_ NO					
	a Deliver	Could not be	28e, PLACE OF	F INJURY — At hor atc. (Specify)	ne, farm,	street, fact	ory, offic			261. LOCATIO		nd Number	or Rural I	Route Number,
国		determined	bullding,	enc. (Specify)						City or lo	wn, State)			
COMPLETED			CIAN: To the best of											i) and menner as stated,
ဗ					TO BEING BEING	ni, in nily o	pirmon, u				piace, an	d due to tr	ie canse(i	ij and menner sa stated.
BE	296. SIGNATURE AND TITLE	OF CERTIFIER	- h. r	(D)	_			29c. LIC	ENSE NUI	MBER		29d. DAT	E SIGNED	(Month, Day, Year)
2	30. NAME AND ADDRESS OF	PERSON WHO	COMPLETED CAUS	BE OF DEATH (ITEN	D_M 127) (Type			D03	599			10	0-20-	-95
	JOHN T. BULK	ELEY,	M.D., 10	08 PINE	BLUF	F ROA	D.	SALT:	SBITE	Y, MAD	VT.ANT	ח מוני	rns	177.00
	31. DATE FILED (Month, Day, 1		32_REGISTRA	R'S SIGNATURE						T. P. Interest				
	3012	V 1000	0											DUMU 48 D 400

		1 - STATE REGISTRAR	STATE OF MARYLAN	ID / DEPARTM			MENTAL HYGIEN		
	'n	1. DECEDENT'B NAME (First, Middle, Lest)		Gn	agey		40 1	DAY YEAR	3. TIME OF DEATH 7:35 PM
P	-	219-03-8024	□ M 2 PLF 7		UNDER 1 YEAR INTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	B. BIR	THPLACE (State or Foreign intry)
. 2, 3 should	CTOR	9a. FACILITY NAME (If not institution, give street North Arus RESIDENCE OF DECEDENT	idel Hosp	ita/ "	Glev	A Bur	nie	9c. COUNTY OF	A 1 11
if. Pages 1,	DIREC	10s. STATE 10b. COUNTY	Arundel		ofton	TION			10d. INSIDE CITY LIMITS? 1 YES 2 TYNO
n. ansit permit.	FUNERAL	100. STREET AND NUMBER 1543 Crofton Par	rkway			21114		US A	WHAT COUNTRY?
5-0020 nding physician. Is the burial-transit	BY FUN	11. MARITAL STATUS 12 1	P. WAS DECEDENT EVER IN U. FORCES? 1 YES: IF YES, GIVE WAR OR DATE	2 NO	If yes, spe	ENDENT OF HISPAN ocity Cuban, Maxican 25 NO Specify.	IC ORIGIN? (Specify Yen, Puerto Rican, atc.)	s or No — 14. RA Bla	CE — American Indian, sick, White, atc. ec/ly:
or after	LETED	15. DECEDENT'S EDUCATI (Specify only highest grade con Elementary/Secondary (0-12)	ION 16 np/eted) 16 college (1-4 or 5+)	Se. DECEDENT'S USI (Give kind of work life. Do NOT use re	done during mos	ON st of working	16b. KIND OF BU	I SINESS/INDUSTRY	White
The hospital detached for	COMPL	17. FATHER'S NAME (First, Middle, Last)	4	Nurse		18. MOTHER'S NAM	Menta ME (First, Middle, Maiden	1 Healt	: h
RYL ed by the uld be at	BE	Saul Gr	oss		-	Leota			
MAR retained 5 should notified	2	Diane Viney					loute Number, City or Tox		
E So De		20a, METHOD OF DISPOSITION		ACE AND DATE OF D	ISPOSITION (Na		DATE 20c. LC	Lle, MD	
MOR age 6 may director, p		1 Durial 2 Cremation 3 Ramoval	Met	ry, crematory or other		10)/23 Ca	tonsvil	le. MD
ALTIMOR death. Page 6 ma to funeral director, p I. examiner must		21. SIGNATURE OF MINERAL BEINGE LICENS	ier.		22. NAME AN	D ADDRESS OF FAC	CILITY		
×		10 de la	mar	_	495 R	itohio	Sons Fund	onno Do	me rk MD21146
filled in tion, or rei		23. PART/1. Enter the diseases, or com- ahock, or heert feilure. Liet IMMEDIATE CAUSE (Final disease or condition resulting in death)	Cerebrove	ascula	enter the mod	de of dying, such	ss cardisc or resp	Iratory srrest,	Approximate Interval Between Onset and Death
executed n and com to burial, imatic ev	CATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A CO						J
certificate of the part of the	TIF	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CO	DNSEQUENCE OF):					
the death the attend d Mental H injury, or	뜅	DART II Other classification with a							
signed by Health and Wrs amy I	MEDICAL	PART II. Other significent conditions of MI Tral Valve Abillahum Ch	disease,	- 1	he underlying	1 0	Part I. 24a. WAS AN PERFOI	RMED?	Ib. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
AL KE taw requi has been s Dept. of H		DID TOBACCO USE CONTRIB	UTE TO CAUSE OF I	DEATH YES	□ NO □	UNCERTAIN		10.4	
N: The tav ficate has State Dep	SICIAN		OSPITAL:		THER:				
SICIAN: The certificate in the State it, or Item	PHYS	1 YES 2 NO 1) 27. MANNER OF DEATH	Inpatient 2 ER/Outpatie	28b. TIME O	F 28c, INJU	5 Residence E	28d. DESCRIBE HOW I	NJURY OCCURED	
After this death with smarked	ВУ Р	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJURY	WOI	RK? 'ES 2 NO			
OR ATTENDING DIRECTOR: After hours after death item 28 is ma	ED	3 Suicide 8 Could not be 4 Homicide determined	28a. PLACE OF INJURY — building, atc. (Specify)	At home, farm, atree	et, factory, offica		28f. LOCATION (Street City or Town, State)	and Number or Rural	l Route Number,
로 기 2 도	COMPLET	29a. CERTIFIER (Check only one) 1 💢 CERTIFYING PHYSICIAN DESCRIPTION OF CONTROL OF CON							(a) and manner on stated.
TO THE HOSPITAL TO THE FUNERAL DE filed within 72 IMPORTANT: II	BE	365 SIGNATURE AND TITLE OF CERTIFIER	M.D.			29c. LICENSE NUMI	BER	29d. DATE SIGNE	D (Month, Day, Year)
	5	Ali Saif WITH AN	ompleted cause of DEATH	30 \ HO>	pital D	rive, Gl	en Burni		
		31. DATE FILED (Month, Day, Year) OCT 2 6 1995	32. REGISTRAR'S SIGNATU	PRE PRINCIPAL PR					

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND / DEPARTMEN	OF HEALTH AND MENTAL	HYGIENE
CERTIFICATI	E OF DEATH	BEG NO

1	FOR STATE OF MARY REGISTRAR		ENT OF HEALTH AN	ND MENTAL HYGIE					
ŧ,	1. DECEDENT'S NAME (First, Middle, Last) William Eddie Gr			2. DATE OF DEATH MONTH DAY 1945 3. TIME OF DEATH 1945					
1			NDER 1 YEAR IF UNDER 24 H	IRS. 7. DATE OF BIRTH	8. Bi	RTHPLACE (State or Foreign			
1	225-78-7057 1 🖈 M 2 🗆 F 90. FACILITY NAME (If not institution, give street end number)	43 YRS. MONT		(Month, Day, Year) 10/03/195	52 V	irginia			
DIRECTOR		sing Center 1 Magnolia Dr. LaPlata Charles							
<u> </u>	10e. STATE 10b. COUNTY		WH OR LOCATION			10d. INSIDE CITY			
	Maryland Charles	LaPlat				LIMITS?			
FUNERAL			10f. ZIP CODE	0616		OF WHAT COUNTRY?			
3	RT 2 Box 2337 11. MARITAL STATUS 12. WAS DECEDENT EVER			0646 ISPANIC ORIGIN? (Specify Y	USA	ACE American Indian,			
BY FI	1 Never Married 2 Married FORCES? 1 YE IF YES, GIVE WAR OR			lexican, Puerto Rican, atc.)		llack, White, etc.			
	3 Widowed 4 Divorced					White			
COMPLETED	15. DECEOENT'S EDUCATION (Specify only highest grade completed)	(Give kind of work of life. Do NOT use retire	lone during most of working	16b. KIND OF B	USINESS/INDUSTR	Υ			
2	Elementary/Secondary (0-12) College (1-4 or 5 +)	Laborer	5 0.)	City Al	exandri	a			
8	17. FATHER'S NAME (First, Middle, Last)	Haborer	18. MOTNER	'S NAME (First, Middle, Maide					
BEO	William David Groggs		Lessi	e Pearl Smit	h				
2	19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADD	RESS (Street end Number or I	Rural Route Number, City or To	wn, State, Zip Code)			
- 1	Myrtle Arlene Jackson	Rt 2 Box	2337 LaP1a	ta, MD 20646					
	20s. METHOD OF DISPOSITION 1 1 Burlai 2 Cremation 3 Removal from State 4 Donation 6 Other (Specify)	tob. PLACE AND DATE OF DIS cometery, crematory or other pi Bethel	SPOSITION (Name of lace)	10/31/95 AI	exandri				
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	Jeunes	22. NAME AND ADDRESS (OF FACILITY		4 , 4 11			
	•			M FUNERAL HO 5 Alexandria		313			
	23. PART I. Enter the diseases, or complications that ceus shock, or heart failure. List only one cause on	sed the death. Do not a	nter the mode of dying,	auch as cardiac or rea	piratory arreat,	Approximata			
	IMMEDIATE CAUSE (Finel disease or condition resulting in death)		ICLE WITH	METASTIS	Ś	Interval Between Onaat and Daath			
- 1		S A CONSEQUENCE OF):							
CERTIFICATION	Sequentially list conditions, DUE TO (OR AS	S A CONSEQUENCE OF):							
8	If any, leading to immediate cause. Enter UNDERLYING								
E	Client Muttaters GAGIITS	S A CONSEQUENCE OF):							
#	resulting in death) LAST								
AL C	PART II. Other algnificant conditions contributing to death	but not resulting in the	underlying cause give	n in Part I. 24e. WAS A	N AUTOPSY	24b. WERE AUTOPSY FINDINGS			
2					PAMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE			
Ä						OF DEATH?			
ä									
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL:	OT	26. PLACE OF DEATH	N (Check only one)					
17S	1 ☐ YES 2 MO 1 ☐ InpetIent 2 ☐ ER/O	utpetient 3 DOA 4 K	Nursing Nome 5 - Reside						
BY Pt	27. MANNER OF DEATN 1 Netural 5 Pending 2 Accident Investigation) INJURY	28c. INJURY AT WORK? 1 YES 2 NO	28d. DESCRIBE NOW	INJURY OCCURED				
		RY — At home, ferm, street, pecify)	factory, office	281. LOCATION (Street City or Town, State	and Number or Ru	ral Route Number,			
<u>-</u>	29s. CERTIFIER								
COMPLETED	298. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my known one) 2 MEDICAL EXAMINER: On the best of exeminates					ee(s) and menner so stated.			
BEO	296. SIGNATURE AND TITLE OF CERTIFIES		29c. LICENSI	NUMBER	29d. DATE SIGN	NEO (Month, Day, Year)			
2	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF			00018	10	30/95			
	KICHARO THEILE (MONTH, Day, Year) REGISTRARIS SI	31 SEMINA	ry Rd De	Fex, VA 23	311				
	31. DATE FILED (Morrit, Day, Year) NOV 08 1005 REGISTRAR'S SIA	rhardell							

DIVISION OF VITAL RECORDS. P.O. BOX 68760

BALLIMORE, MARTLAND 21213-0020	d within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dect. of Health and Mental Hydiene prior to burial, cremation, or remonal.	event, the medical examiner must be notified at once.
CONTRACTOR OF ALL ALL ALL ALL ALL ALL ALL ALL ALL AL	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the for the filed within 72 hours after death with the State Debt. of Health and Mental Hydlene prior to burial. cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

	1. DECEDENT'S NAME (First, Middle, L.			-		OAIL	- 01	DEA			HEG. NO.			
	1. DECEDENT S NAME (FIRST, MIOGIE, LI	lat)									ATE OF DEATH	W	YEAR	3. TIME OF DEATH
	WILEY	JAMES			GRAI	BEA	Τ,			OC	TOBER	25.1		5:20P M
1	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE	(In yrs. lest	t birthday)	IF UNDER	1 YEAR	IF UNDER	24 HRS.	7. DA	ATE OF BIRTH		a, BIRTH	IPLACE (State or Formion
1	218-18-2615	1 M 2 F	74		YRS.	MONTHS	DAYS	HOURS	MIN.		fonth, Day, Year)	000	Countr	γ)
		ME (If not institution, give street and number)						Nov. 13,						ryland
oc	ac country									NTY OF D	EATH			
ē	GREATER BALTIMORE MEDICAL CENTER								ON			BA	ALTI	MORE
DIRECTOR		RESIDENCE OF DECEDENT												
E		106. INSIDE								10d. INSIDE CITY LIMITS?				
	Maryland Harford								Be	1 A	Air			1 TYES 2 NO
4	10s. STREET AND NUMBER		101	ZIP COD	E			10g. CIT	IZEN OF W	VHAT COUNTRY?				
FUNERAL	1001 Congr	wingo Road							21	01.4				
Z	11. MARITAL STATUS	12. WAS DECEDEN	T EVED II	MILE ADV	MED	T 40 1				014	IGIN? (Specify Yea			USA
	1 Never Married 2 Married	FORCES7 1	YES	2 N		13.	f yes, sp	ecify Cube	n, Maxicar	n, Puei	rio Rican, atc.)	or No-	14, RACE Black	— American Indian, c, White, atc.
BY	3 Widowed 4 Divorced	IF YES, GIVE W	AR OR D	ATES		1	YES	2 NO	Specify	y:			Specif	
ED			MAT											white
쁘	15. DECEDENT'S (Specify only highest g			(Gh	CEDENT'S	vork done c	CUPATIO	ON at of workin	na		16b. KIND OF BUS	SINESS/INC	DUSTRY	
Ш	Elementary/Secondary (0-12)	College (1-4 or 5+)	life.	Do NOT us	e retired.)								
P P		3		Ele	ctro	nic 1	l'ech	nici	an		IJ.	S. G	over	nment
COMPLET	17. FATHER'S NAME (First, Middle, Last)									ME (Fin	st, Middle, Maiden		OVOLI	and it
	Robert F	li Graybea	.1											
BE	19a. INFORMANT'S NAME (Type/Print)	ci Grayice	-	100	MAH BIO	4000500	. (Da	V.	11411	ша	Sara W	agone	er	
2														
- 8	Nellie M. Graybe	eal		1	001	Conov	ving	o Ro	ad, 1	Bel	Air, M	aryla	and	21014
- 8	20a. METHOD OF DISPOSITION 152 Burlet 2 Cremetion 3 F	lemovel from State	20b	. PLACE A	ND DATE	F DISPOS	ITION /Na	me of		D	ATE 20c. LO	CATION -	City or To	wn, State
l V	4 Donation 5 Other (Specify)	The state of the s	Wes	st N	ottii	ner place) nghan	n Cer	mete	rv 10	0/2	8/95 C	olora	a Ma	breland
1	21. SIGNATURE OFFUNERAL SERVICE	LICENSEE	1			22.1	NAME AN	O ADDRE	SS OF FAC	CILITY	.0/35	OTOLO	A I'K	II y I Culta
	× //	MAdres a	1			Mo	Com	as Fi	mera	al	Home			
	Al street	1 11 1	-	2		13	317	Cokes	sbury	y R	oad, Ab	inado	on. M	1d. 21009
	23. PART I. Enter the diseases,	or complications that	Ceused	the dea	ath. Do n	ot enter	the mo	de of dyl	ing, such	h as c	ardiac or reepi	ratory arr	rest,	Approximata
	ahock, or heert fellu	re. List only one caus												
			96 OH 6	ecii iiile.										interval Between
	iMMEDIATE CAUSE (Final disease or condition					W(E)	R	n	MT	AT) (Onset and Death
	IMMEDIATE CAUSE (Final	GAS	TR	10	CA		RI	TET	ASTI	957)(
	iMMEDIATE CAUSE (Final disease or condition	GAS	TR	10			RI	TET	ASTI	477)(Onset and Death
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ALTIMORE, MARYLAND 21215-0020

FOR STATE REGISTRAR

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1 📉 M 2 🗌 F 85 185-09-4387 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATN DIRECTOR permit. Pages 1, 2, 3 Bel Air Nursing Center Bel Air 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION PA York Delta 10e. STREET AND NUMBER FUNERAL 101. ZIP CODE burial-transit 1084 Atom Road 17314 Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-if yes, specify Cuben, Maxican, Puerlo Ricen, etc.) 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 1 Never Merried 2 Merried 1 TES ZONO BY 3 Newsday 4 Divorced Specify use as the ED 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working (Specify only highest grade comple (Give kind of work done life. Do NOT use retired.) 늡 funeral director, page 5 should be detached for Elementary/Secondary (0-12) College (1-4 or 5 +) COMPL 12 Truck Driver be notified at once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) William Griffith BE Clara Jones 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Barbara A. Miller Chestnut St., Cardiff, MD, 20e. METHOD OF DISPOSITION
1 (X Burlal 2 Cremetion 3 Removal from State
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of DATE must Comptery 10/22 Slateville 21. SIGNATURE OF FUNERAL SERVICE LICENSEE examiner Harkins F.H.Inc., Delta, PA, 17314 the medicai 23. Point L Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest. filled in by shock, or heart fellure. Liet only one cause on each line. 6 IMMEDIATE CAUSE (Finel the cremation, disease or condition Heart Failure and completely fi burial, cremation Congestive resulting in death) other traumatic event, DUE TO (OR AS A CONSEQUENCE OF Urtery Oronary CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): prior to If any, leading to immediate cause. Enter UNDERLYING physician CAUSE (Diseese or Injury DUE TO (OR AS A CONSEQUENCE OF) the attending p that initiated events resulting in deeth) LAST 6 shows any injury, PART II. Other algnificent conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL signed by the 1 TES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO 🔀 UNCERTAIN PHYSICIAN: Dept. 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) **EXAMINER?** HOSPITAL: OTHER:
4 Nursing Nome 5 Residence 8 Other (Specify) 1 VES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 9 27. MANNER OF DEATH 28e. DATE OF INJURY 28c. INJURY AT WORK? 1 Natural 26b. TIME O 28d. DESCRIBE HOW INJURY OCCURED this (marked, INJURY 5 Pending Invastigation М 1 YES 2 NO BY Accident 26e. PLACE OF INJURY — Al home, farm, atreet, fectory, offica building, etc. (Specify) 64 3 Suicide 261. LOCATION (Street end Number or Rural Route Number, City or Town, State) 6 Could not be DIRECTOR: COMPLETED 28 4 Nomicide 29e. CERTIFIER 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the lime, data and place, end due to the cause(e) and menner es atated. FUNERAL I = 2 MEDICAL EXAMINER: On the besis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(a) end menner as stated. TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: 1 296. SIGNATURE AND TULE OF CERTIFIER 29c. LICENSE NUMBER H for D34652 MD 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) COTT HASWELL BEL AIR NORTH AVE MARYLAND 31. DATE FILED (Month, Day, Year) 32 REGISTRAR'S SIGNATURE Lebo Savelson Roylell 1995

special server 30, 8

6. AGE (In yrs. lest birthday)

CERTIFICATE OF DEATH

IF UNDER 1 YEAR

DAYS

MONTHS

YRS.

IF UNDER 24 HRS

HOURS

95 33659 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 2. DATE OF DEATN 3. TIME OF DEATH OC+ 10 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State or Foreign Country) /28/1909 09 | Maryland Harford 10d. INSIDE CITY NES 2 NO 10g. CITIZEN OF WHAT COUNTRY? USA 14. RACE — American Indian, Black, White, etc. White 16b. KIND OF BUSINESS/INDUSTRY Sewing Factory 20c. LOCATION - City or Town, State /b5 Delta PA Approximete Interval Betwe Onset and Death

DHMH-16 Rev 1/89

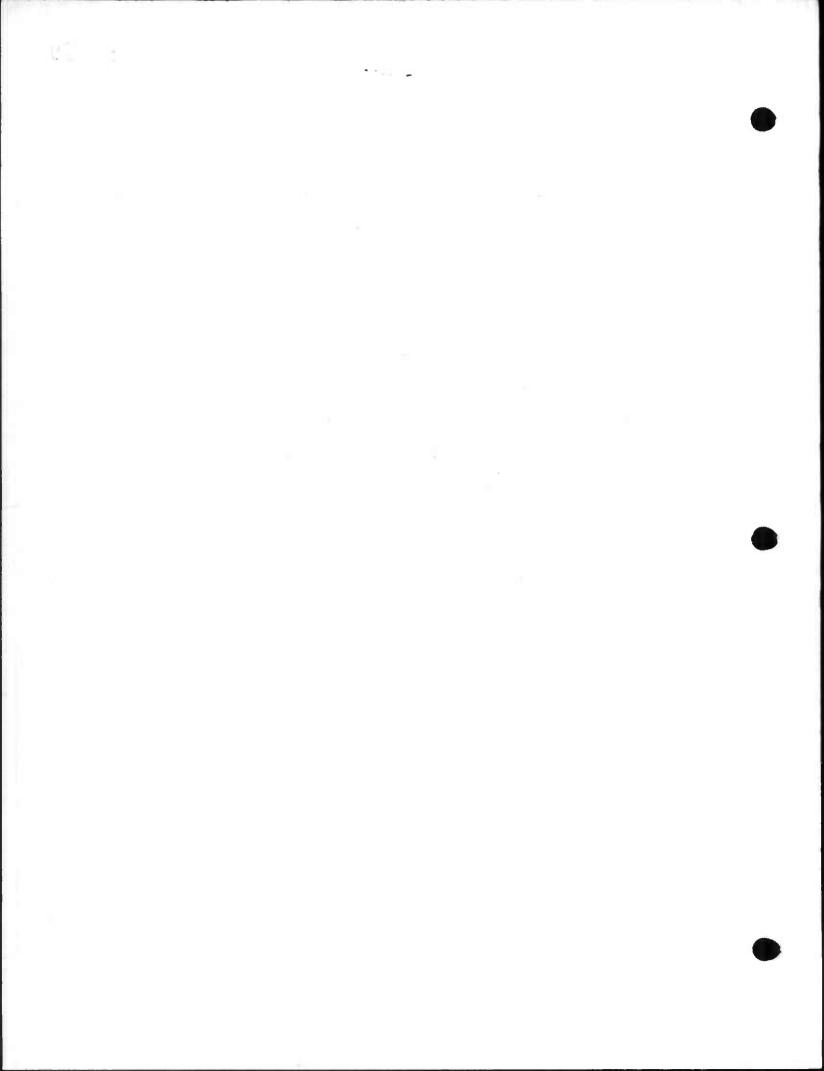
24b. WERE AUTOPSY FINDINGS

AVAILABLE PRIOR TO COMPLETION OF CAUSE

OF DEATH? 1 TYES 2 NO

29d. DATE SIGNED (Month, Day, Year,

October 18, 1995



DIVISION OF VITAL RECORDS P.O. BOX 68760

		1 - FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPAR	TMENT OF H	IEALTH AND I	MENTAL HYGIEN		
		1. DECEDENT'S NAME (First, Middle, Last) GUY H.	GARI		SR.		2. DATE OF DEATH	3. TIME OF DEATH	
		4. SOCIAL SECURITY NUMBER		- ANU r yrs. leat birthdey)	JT.	IF UNDER 24 HRS.	OCTOBER 2	5,1995 YEAR	8:30 P M
pinor		212-30-7610 9e. FACILITY NAME (If not institution, give str	1 M 2 □ F 6	4 YRS.	MONTHS DAYS	HOURS MIN.	(Month, Day, Year) APRIL 16,1	Cou	RYLAND
1, 2, 3 should	стов	19516 MUNCASTER R			·	WOOD	2017	MONTGO	
permit. Pages 1,	DIRE	MARYLAND MONT	GOMERY	77	Y, TOWN OR LOCAT	TION			10d. INSIDE CITY LIMITS? 1 YES 2 NO
SS	FUNERAL	19516 MUNCASTER	ROAD			ZIP CODE	855	UNITED	STATES
attending physician. Se as the burial-transit	D BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2 NO	If yes, sp	ENDENT OF HISPAN ecity Cuban, Mexica 2 NO Specify	IIC ORIGIN? (Specify Yea n, Puerlo Rican, atc.)	Bie	CE — American Indian, sick, White, atc.
To a v	COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12)	ATION ::ompleted) College (1-4 or 5+)		USUAL OCCUPATION Work done during more retired.)		16b. KIND OF BUS	SINESS/INDUSTRY	
The hospital detached to once.	OMP	8 17. FATHER'S NAME (First, Middle, Last)	0	FARMER			FARM		
# 8 %	BE CO		LAND			DELL/	ME (First, Middle, Malden A MAX		
retained 5 should notified	5	190. INFORMANT'S NAME (Type/Print)	T.C.			nd Number or Rural F	Route Number, City or Town	m, State, Zip Code)	
ay be		BARBARA A RICKET 20e METHOD OF DISPOSITION 1 ID Burlel 2 Cremation 3 Remove	206.	PLACE AND DATE	MUNCASTI OF DISPOSITION (Na	me of		MD. 2085 CATION — City of	
3 ect 6		4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICE	S	EALS FAF	RM CEMETI		/30/95 ETC		
9 = 0		Marie	N. Ba	rber	MURIE	30X 5038	BER FUNERA LAYTONSV	ILLE MAR	
ted within 24 hours after completely filled in by the ial, cremation, or removal: event, the medical		23. PART I. Enter the diseases, or conshock, or heart failure. L. IMMEDIATE CAUSE (Final disease or condition resulting in death)	emplications that caused list only one cause on ea	Cons	ot anter the mo	de of dying, such	n as cardiac or reapi	ratory arrest,	Approximate Interval Between Onset and Death
th certificate be executed ending physician and con I Hygiene prior to burial, or other traumatic et	ERTIFICATION	Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A (
ires that the d signed by the lealth and Me	EDICAL C	PART II. Other significant conditions	contributing to death bu	t not resulting i	n the underlying	ceuse given in i	Part I. 24a. WAS AN PERFOR 1 TYES 2	RMED?	Ib. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
been t. of	N: M	DID TOBACCO USE CONTR	BUTE TO CAUSE OF	DEATH YE	S I NO D	UNCERTAIN	10		1 TES 2 NO
ate h	SICIAN:		HOSPITAL: 1 Inpatient 2 ER/Outpar	T	H (Check only one) OTHER:				
PHY:	PHY	27. MANNER OF DEATH 1 Natural 5 Pending	28e. DATE OF INJURY (Month, Day, Year)	28b, TiM	E DF 28c. INJU	JRY AT RK?	8 U Other (Specify) 28d. DESCRIBE HOW II	NJURY OCCURED	
TTENDI CTOR: A after d	TED BY	2 Accident Investigation 3 Suicide 8 Could not be determined	28e. PLACE OF INJURY - building, etc. (Specif	– Al home, farm, s	treet, factory, office		281. LOCATION (Street e City or Town, Stete)	and Number or Rural	Route Number,
B SE SE	COMPLE		AN: To the best of my knowle On the basis of examination						(a) and manner so stated.
TO THE HOSPITAL OF TO THE FUNERAL DE filed within 72 ho	BE	29b. SIGNATURE AND TITLE OF CENTER	MU	\sqrt{m}	Ω	29c. LICENSE NUM		29d. DATE SIGNE	R 26, 1995
M	5	Q. NAME AND ADDRESS OF BRISON WHO	COMPLETED CAUSE OF DEAL	H (ITEM 27) (Type,	Print)	nvo P	hilor) Oh	or MD 2688
1		31. DATE FILED (Month, Dey, Year) OCT 2 7 1995	32. REGISTHAR'S SIGNAT	rune Idalli					

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

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		1. DECEDENT'S NAME (First	, Middle, Last)								2. DATE OF DEATH 3. TIME OF DEATH				3. TIME OF DEATH
		Carolyn H	Colyn Estelle Gill October 26, 1995						12 463						
		4, SOCIAL SECURITY NUMBER 5. SEX			6. AGE (in yrs	6. AGE (in yrs. lest birthday) IF UNDER 1 YEAR IF			I I I I I I I I I I I I I I I I I I I		BUDTH	BIRTHIN ACE COLL C		PLACE (State or Foreign	
-		577-56-8931	1 M 2 X F	54	YRS.	MONTHS	DAYS	HOURS	MIN.	Feb.	8, 19	941 Washington,			
3 should		9e. FACILITY NAME (If not in	stitution, give s	treet and number)			9b. CIT	Y, TOWN	OR LOCAT	ION OF DE			~ _	NTY OF DE	
2,	DIRECTOR	11722 Whitt		oad			Gle	enda	le_				Prin	ce G	eorge's
ges 1	l m	10+. STATE	10b. COUNT	Y		10c. CI	TY, TOWN	OR LOCA	TION					Т	10d. INSIDE CITY
permit. Pages 1, 2,		Maryland	Prince	e George'	s	G1	enda:	le							LIMITS?
E 86	₹ A	10e. STREET AND NUMBER						10	r. ZIP COD	E			10g. CIT	ZEN OF W	THAT COUNTRY?
an. ransit	FUNERAL	11722 Whit	tier I							0721				ted	States
5-0020 inding physician. as the burial-transit	BY FU	11. MARITAL STATUS 1 Never Merried 2 2 3 Wildowed 4 Divo			NT EVER IN U.S 1 YES 2 WAR OR DATES	NO		Il yes, s	CENDENT (pecify Cubic \$ 2\(\begin{align*} \text{NO} \\ \text{NO} \\	an, Mexice	IIC ORIGIN? (1 n, Puerto Rici /:	Specify Yes in, etc.)	or No-	Specifi Specifi	
ttendi			EOENT'S EDU		16a	. DECEDENT'	S USUAL C	CCUPAT	ON		16h XI	NO OF BUS	IMESS/IME	Bla	CK
al or atte	ETED	(Specify onl	y highest grade 1-12)	College (1-4 or 5	4)	(Give kind of life. Do NOT	work done use retired.)	during m	ost of world	_					pement
3 2 6	۵			4	" Ch	ild D	evel	pem	ent I	Direc	ctor			ter	
1 9 5 E	00	17. FATHER'S NAME (First, M	liddle, Last)						18. MOT	HER'S NA	ME (First, Mide	dle, Maiden	Surname)		
5 8 To	BE	Charles Le								-	Este				
y be retained by be retained the sage 5 should be notified	10	Ronald E. G		Sr.							Route Number, Glenda			0721	
TO, par		20a METHOD OF DISPOSIT 1 Burlel 2 Cremetic 4 Donation 5 Other	n 3 🗆 Rem	oval from State	20b. PLA cemetery Res	CEANDDATE , cremetory or UTTEC	of DISPO	Ceme	_{eme ol}	, 1	0/30			City or Tov	vn, State ryland
. Page ral direc	- 87	21. SIGNATURE FUNERA	L SERVICE LIC	ENSEE 1	e .	3					I Ser				20012
0 = 0		Henry	4 0.	DIL	Lins)									on, D.C.
hours after d d in by the i or removal,	4	Shock, or h	sesses, or d	complications the	at causad the	daath. Do	not anta	tha me	da of dy	ing, suci	ss cardisc	or respi	ratory srr	rest,	Approximats
		IMMEDIATE CAUSE (Fir		and day one day	asc on adon	······································									Interval Between Onset and Deat
ompletely fille cremation, event, the		disease or condition resulting in death)	\rightarrow	•	static			nce	<u> </u>						
2 2 2 m					OR AS A CON										
and and	CATION	Sequantially list conditi		D. A	irator										
ficate be explysician a ne prior to her traum	<u>¥</u>	if sny, lasding to imma- csuse. Entar UNDERLY	NG	c.			,								į
nding phy Hygiene or other	Ē	CAUSE (Disease or Injuthat initiated events		DUE TO	(OR AS A CON	SEQUENCE (OF):								
	ERTIFI	resulting in death) LAS	' (d											
Me de S	C	PART ii. Other significa	nt condition	s contributing to	death but n	ot rasuiting	in tha u	ndariyin	g cause	given in	Part i. 24	a. WAS AN	AUTOPSY	24b.	WERE AUTOPSY FINDINGS
that the ed by the and any lin	MEDICAL											PERFOR			AWAILABLE PRIOR TO COMPLETION OF CAUSE
Se sign se sig	밀											☐ TES 2	W NO		OF DEATH?
N: The law requires icate has been sign State Dept. of Heal Item 23 shows		DID TOBACCO U	SE CONTI	RIBUTE TO CA	AUSE OF D	EATH Y	ES 🗆	NO [JUNC	ERTAIN	11/2				1 163 2 100
The little has ate De	SICIAN	25. WAS CASE REFERRED TO EXAMINER?				LACE OF OE	TH (Check	only one)							
SICIAN: The law requestricate has been the State Dept. of I, or Item 23 sho	977	1 TES 2 X NO		HOSPITAL:	☐ ER/Outpation	3 🗆 DOA	4 Nur	R: sing Hon	10 5 XR	ealdence	8 🗆 Other (S	pecify)			
this with	ву РНУ		Pending Investigation	28e. DATE OF (Month, D		28b. Til 8N	ME OF JURY M	W	JURY AT ORK? YES 2	□ NO	28d. DESCR	BE HOW IP	JURY OCC	CUREO	
CTOR: A after de 28 ls	ED	3 Suicide 8	Could not be determined	28e. PLACE 0 building,	OF INJURY — At, etc. (Specify)	home, ferm,	street, fac	lory, offic	•		281. LOCATIO	ON (Street e own, State)	nd Number	or Rural Ro	nute Number,
DIR Pour	PLE	29e. CERTIFIER (Check only	IFYING PHYSI	CIAN: To the best of	f my knowledge	, death occur	red at the t	lme, dete	and place	end due	to the causel	a) and men	ner es elet	ad .	
THE HOSPITAL THE FUNERAL filed within 72 PORTANT: If	COMPLE														end manner ee stated.
TO THE HOSPI TO THE FUNEF TO FIRED WITHIN	BE C	296. SIGNATURE AND TITLE	OF DERTHFIEF	1/10					29c. LICE	ENSE NUM	BER		29d. DATI	E SIGNED (Month, Day, Year)
5 5 3 M	TO E	Romb	U. Yus	Kins, M					D43	162			▶ 00	ctobe	er 27, 1995
77		Melvin W.						Ave	nue,	N.W	., Was	hing	ton,	D.C.	20060
10		31. DATE FILED (Month, Day, OCT 2 7 19	195 A	32. REGISTRA	AR'S SIGNATUR										
	الصد	- 10													

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

12.... is given by the late of the govern1 - STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

A SOCIAL SECURITY NUMBER

Mille Gregor

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HOURS 531-56-2886 1 M 2 X F 95 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH Suburban Hospital Bethesda CTO RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION DIRE Rockville Maryland Montgomery permit. 10e. STREET AND NUMBER 10f. ZIP CODE FUNERAL 20852 11005 Rosemont Drive burial-transit after death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—It yes, specify Cuban, Maxican, Puerto Rican, etc.) FORCES? 1 YES 2 FYES, GIVE WAR OR DATES 1 Never Married 2 Married 1 YES 2 X NO Specify: BY 3 XWidowed 4 Divorced as the ED 15. DECEDENT'S EDUCATION 18a. DECEDENT'S USUAL OCCUPATION use (Specify only highest grade during most of working (Give kind of work done life. Do NOT use retired.) ET 10 Elementary/Secondary (0-12) College (1-4 or 5 +) COMPL detached 12 Homemaker once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) 70 Cecilia Jaques director, page 5 should be John Koller notified 19a INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 136 Cedar Avenue, Rockville Centre, New York 11570 Peter R. Gregor 9 20a. METHOD OF DISPOSITION
1X Burial 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE must Parklawn Memorial Park 4 Donation 8 Other (Specify) 22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc., 7557 21. SIGNATURE OF FUNERAL SERVICE LICENSEE medical examiner Michel Wisconsin Ave., Bethesda, MD 20814-3501 M00348 filled in by the 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdisc or respiratory arrest, ahock, or heart fellure. List only one cause on each line. 9 IMMEDIATE CAUSE (Final the disesse or condition cremation, Myocardial Infarction completely event, 1 reaulting in desth) DUE TO (OR AS A CONSEQUENCE OF) executed burial. traumatic and CERTIFICATION Sequentially list conditions, OUE TO (OR AS A CONSEQUENCE OF): 9 physician a s attending physician lental Hygiene prior to if any, leading to immediate cause. Enter UNDERLYING 2 certificate CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events reaulting in death) LAST 6 death signed by the atter Health and Mental any Injury, PART II. Other algnificant conditions contributing to deeth but not resulting in the underlying cause given in Part I. the MEDICAL that requires shows a has been of h DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\Boxed{1}\) NO \(\Boxed{1}\) UNCERTAIN \(\Boxed{1}\) PHYSICIAN: WE 23 26. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL The tem After this certificate I death with the State HOSPITAL: OTHER:
4 Nursing Homa 5 Residence 6 Other (Specify) 1 YES 2 XNO 1 Inpetient 2 ER/Outpetient 3 DOA ATTENDING PHYSICIAN: 0 27 MANNER OF DEATH 28a. DATE OF INJURY 26b, TIME OF 28c. INJURY AT WORK? 28d DESCRIBE HOW INJURY OCCURED marked, INJURY 1 XNatural 5 Pending М 1 YES 2 NO BY 2 Accident Investigation 26a. PLACE OF INJURY - At home, ferm, street, fectory, office 3 Suicide 69 8 Could not be DIRECTOR: A ED 4 Homicide 50 determined 回 Item BH 29a. CERTIFIER 1X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. COMPL TO THE HOSPITAL (TO THE FUNERAL DE filed within 72 ho 29b. TIGHATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE 015236 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Carl I. Margolis, M.D., 11125 Rockville Pike, #211, Rockville, Maryland

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE BEG NO 2. DATE OF DEATH 3. TIME OF DEATH YEAR October 21,1995 8:01A M 7. DATE OF BIRTH (Month, Day, Year)
Dec. 13,1899 6. BIRTHPLACE (State or Foreign Pennsylvania 9c. COUNTY OF DEATH Montgomery 10d, INSIDE CITY LIMITS? 1X YES 2 NO 10g. CITIZEN OF WHAT COUNTRY? United States 14. RACE — American Indian, Black, White, etc. Specify: White 16b. KIND OF BUSINESS/INDUSTRY Own Home 20c. LOCATION - City or Town, Stata Rockville, Maryland

CERTIFICATE OF DEATH

MONTHS

IF UNDER 1 YEAR IF UNDER 24 HRS.

DAYS

(AKA Millie Gregor)

6. AGE (In yrs. last birthday)

Interval Between Onaet and Death Minutes

24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 X NO

24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 TYES 2 TYNO

281, LOCATION (Street and Number or Rural Route Number, City or Town, State)

2 MEDICAL EXAMINER: On the besia of examination and/or investigation, in my opinion, death occurse at the time, data and place, and due to the cause(a) and manner as stated. 29d. DATE SIGNED (Month, Day, Year)

31. DATE FILED (Month, Dey, Year)
OCT 24 1995 32. REGISTRAR'S SIGNATURE 24 1995

October 23,1995

± × ×

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be defached for use as the buriat-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Merial Hygiene prior to buriat, cremation, or removal.

IMPORTANT: If I liem 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

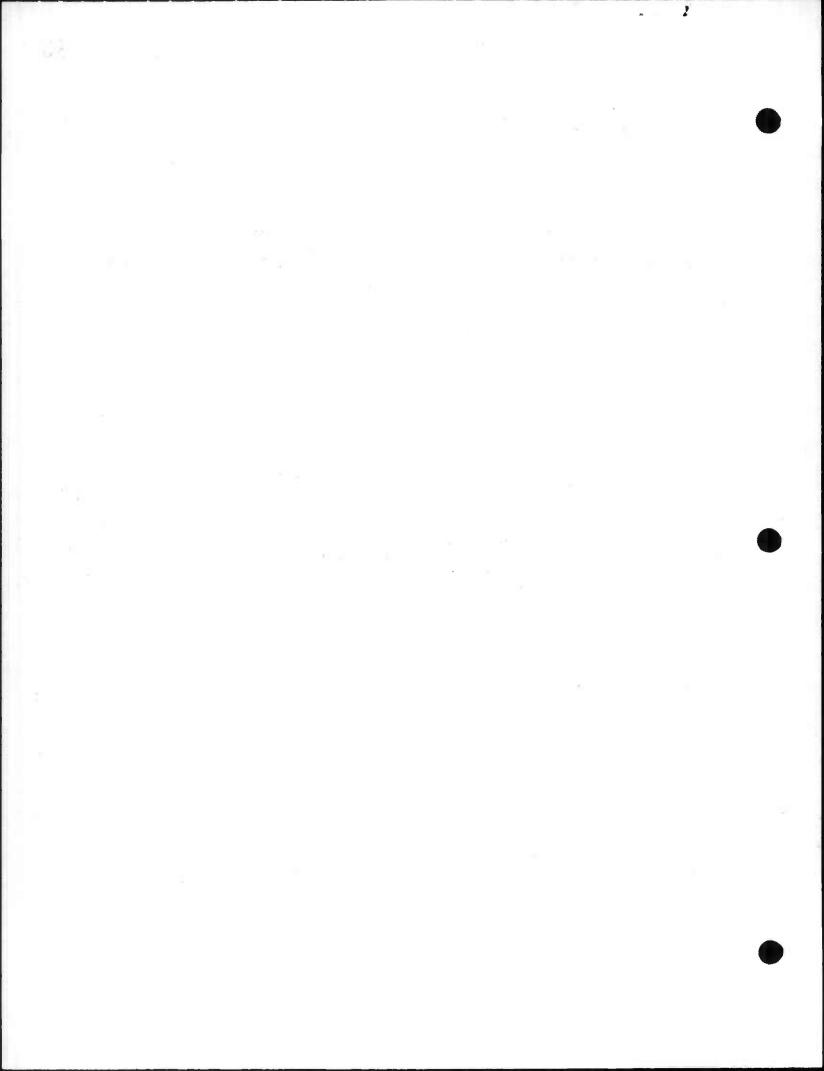
DIVISION OF VITAL RECORDS, P.O. BOX 68760

1

FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REG. NO.

DECEDENT'S NAME (First, Middle, Lest)

_	112310111111		UL	I I II I I I	AIL	PUEAIR	REG. NO.		
	1. DECEDENT'S NAME (First, Middle, Last)	HRZ	PKI	iah	Hu	tzell	2. DATE OF DEATH MONTH DA	5/50	YEAR 200/
	4. SOCIAL SECURITY NUMBER I 215-18-1391	5. SÉX 8. AI	GE (In yrs. last t		ONTHS DAY		7. DATE OF BIRTH (Month, Day, Year)	/	8. BIRTHPLACE (State or Foreign Country)
	9a. FACILITY NAME (If not Institution, give s	treet and number			AITY POW	N OR LOCATION OF D	July 9, 1		Maryland
OR	Washington County				L GIT, IOW	Hagersto		9c. COUN	Washington
2	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY	,		40. CITY T	20121 02 10				
DIRECTOR	Maryland Wa	ashington		100, 0117, 1	OWN OR LO	Hagersto	wn		10d. INSIDE CITY LIMITS? 1 YES 2 NO
¥	10e. STREET AND NUMBER					101. ZIP CODE		10g. CITIZ	ZEN OF WHAT COUNTRY?
ij l	18303 College Roa	ad				21740			USA
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 Narried 3 Nidowed 4 Divorced	12. WAS DECEDENT EVE FORCES? 1 YOUR STEEL YES, GIVE WAR OF	ES 2 NO		If yes,	ECENDENT OF HISPA specify Cuban, Maxic ES 2 XNO Speci	NIC ORIGIN? (Specify Yes in, Puerto Rican, etc.) y:	or No-	14. RACE — American Indian, Black, White, etc. Specify; White
	15. DECEDENT'S EDUC		16a. DECE	EDENT'S USI	UAL OCCUPA	TION	16b. KIND OF BUS	INESS/IND	
E	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give	kind of work to NOT use re	done during stired.)	most of working	The time of book	ALL GOVING	outh)
COMPLETED	12	0			mec	hanic		ai	rcraft
8	17. FATHER'S NAME (First, Middle, Last)					18. MOTNER'S NA	ME (First, Middle, Malden	_	
BE C	Edward L. Hutzell	L				Myrtle			
	19a. INFORMANT'S NAME (Type/Print)		19b. I	MAILING AD	DRESS (Street	t and Number or Rural	Route Number, City or Town	Stem Zin	Codel
2	Lois L. Hutzell								yland 21740
	20a. METHOD OF DISPOSITION 1 2 Burlel 2 Cremation 3 Remote 4 Donation 5 Other (Specify)	oval from State	20b. PLACE AN	D DATE OF D	DISPOSITION place)	Name of	DATE 20c. LO	CATION C	Otty or Town, State
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE	, Kest	nave	11 Celli	AND ADDRESS OF FA	-21-95 Ha	gerst	own, Maryland
	· Scott	Min	wet		MINN	ICH FUNER	AL HOME	rator	n, Md. 21740
	23. PART I. Enter the disease, or o shock, or heert failure. I IMMEDIATE CAUSE (Finel disease or condition resulting in death)	List only one ceuse or	each line.	di	entar the r	node of dying, aud	ton	ratory arre	Approximata interval Batweer Onset and Dazit
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):							Cu	la direus	
	PART ii. Other significent conditions	s contributing to death	but not rea	uiting in ti	he underly	ing cause given in	Part i. 24a. WAS AN	A) FTORCY	24b. WERE AUTOPSY FINDINGS
EDICAL	obesity.	hyperte	15 SI	òn		mg codae given in	PERFOR	MED?	AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
Σ	DID TOBACCO USE CONTR	URLITE TO CALICE	OF DEATH	I VEC		/			1 TYES 2 NO
¥	25. WAS CASE REFERRED TO MEDICAL	GBOTE TO CAUSE			Check only or		111		
딛	EXAMINER?	HOSPITAL:		01	THER:				
PHYSICIAN:	27. MANNER OF DEATH	1 Inpetient 2 ER/O				ome 5 Residence			
BY P	1 Netural 5 Pending 2 Accident Investigation	28a. DATE OF INJUR (Month, Day, Yea		266. TIME OF INJURY		NJURY AT YORK? YES 2 NO	26d. DEŞCRIBE NOW IN	JURY OCCI	URED
ETED	3 Suicide 8 Could not be determined	28e. PLACE OF INJU building, etc. (S	IRY — At homa pecify)	, farm, stree	it, factory, of	Hen	28f. LOCATION (Street as City or Town, State)	nd Number o	or Bural Route Number,
MPLE	29a. CERTIFIER (Check only one)	CIAN: To the best of my kn	owledge, death	occurred at	the time, da	ta and place, and dua	to the cause(a) and man	ner an state	d.
<u> </u>	2 MEDICAL EXAMINER	R: On the basis of examina	tion and/or invi	estigation, in	my opinion	death occured at the	time, data and place, and	due to the	cause(a) and manner as stated.
O BE	296. SIGNATURE AND THE CONSTSTANT					D26	606	29d. DATE	SIGNED (Month, Day, Year)
ř	30. NAME AND ADDRESS OF PERSON WHO	POMPLETED CAUSE OF	DEATN (ITEM 2	T) (Type, Prin	11)	A. A.	a Head	~	6, MD
	31. DAG (CLIP 12 1110 1995	92. FISMAR'S S	MATURE	V () /	1 W	in the	e Truge	7.79	(DWM 2774)



BALTIMORE, MARYLAND 21215-0020

F VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withing a high death. Page 6 may be retained by the hospital or attending physician.	is certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should thin the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	d, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. B	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate	TO THE FUNERAL DIRECTOR; After this certificate has been signed by the attending physic be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene principle within the state of the principle.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other to

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATN MONTH DAY YEAR 3. TIME OF DEATN MONTH DAY YEAR 1. 30													
	JOHN		EROY HU	DSON						October 15, 1995			YEAR	1:30 a m
	4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In yr	rs. last birthday)	IF UNDE	R 1 YEAR	IF UNDE	P 24 HRS.	7. DATE OF			8. BIRTH	IPLACE (State or Foreign
	216-14-91		1 🔀 M 2 🗆 F	74	YRS.	YRS. WHITE DAYS HOURS WITH					January 1,1921 1			ryland
Œ	90. FACILITY NAME (If not in ATLANTIC G			Τ.				OR LOCAT	ION OF DE	EATN			RCES	
5	RESIDENCE OF DEC				BERLIN WORCESTE							LEK		
DIRECTOR	10a. STATE	10b. COUNT			1	TY, TOWN								10d, INSIDE CITY LIMITS?
	Maryland		cester			now	Hill	L						1 WES 2 NO
FUNERAL	Nassawang		s Dr.				10	2 1	863				USA	WHAT COUNTRY?
5	11. MARITAL STATUS		12. WAS DECEDEN			13.	WAS DE	CENDENT	OF HISPAN	VIC ORIGIN?	Specify Yes	or No—	14. RACE	— American Indian.
ВУ Е	1 Never Married 2 🔀 3 Widowed 4 Divo		FORCES?				If yes, s	pecify Cub S 2 X NO	en, Maxica	n, Puerto Ric	an, atc.)		Speci	
	15, DEC	EDENT'S EDU	ICATION	166	a. DECEDENT'S	USUAL O	CCUPAT	ION	_	16b. K	IND OF BUS	INESS/IN	Whit	Le
П	Elementary/Secondary (0	y highest grade 3-12)	College (1-4 or 5		(Give kind of life, Do NOT u	work done ise retired.)	during m	ost of work	ing	2.11				i
COMPLETED	12		0		Hardw	are	mana	ager		A	dkins	Co.		
Ö	17. FATHER'S NAME (First, M	fiddle, Last)						16. MOT	NER'S NA	ME (First, Mid	dle, Maiden	Sumame)		
BE (Theodore		Huds	on				Be	ssie		J	ohns	on	
0	19a. INFORMANT'S NAME (1									Route Number,				WD 01060
	Natalie W.		n				_		HII	1 Dr.				MD 21863
	1 ☐ Burial 2 ☑ Crematic	on 3 🗆 Rem	ioval from State	cemeter	ACE AND DATE y, cremetory or isbury	other plece))			10/16			oury,	,
	21. SIGNATURE OF FUNERA	L SEMICE LA	орудее	1 541	. I S D G L y	22.	NAME A	ND ADDRE	SS OF FA	CILITY		11130	oury,	110
	22. NAME AND ADDRESS OF FACILITY Holloway Funeral Home 50! Snow Hill Rd., Salisbury, MD 2											2 180 1		
	23. PART I. Enter the di	Iseases, or	complications the	t caused the	a daath. Do	not anter	the m	ode of dy	ing, suci	h as cardia	c or respi	ratory an	reat,	Approximata
	anock, or h	aart fallure.	List only one cau	ise ón each	lina.									Interval Between Onset and Death
												< 240		
	resulting in death) a. YOCOLULE Delivered BOTO TO (OR AS A CONSEQUENCE OF):													
NO	disease or condition resulting in death) a. Myccocked cockemics By TO (OR AS A CONSEQUENCE OF): Constant of the property of											14 mm		
ATI	Sequentially list conditions, If any, leading to immediate Cause Prizer UNDERLYING											water >		
임	CAUSE (Disease or Injury that initiated events DUE TO (OR AS A CONSEQUENCE OF):													
CERTIFICATION	resulting in death) LAST													
	PART II. Other algolfice	nt condition	na contributing to	deeth but n	not resulting	In the ur	nderivir	og celise	alven In	Part I 2	ta. WAS AN	AITTOREV	245	WERE AUTOPSY FINDINGS
MEDICAL					,		,	.9	g		PERFOR	MED?	1	AVAILABLE PRIOR TO COMPLETION OF CAUSE
										— '	YES 2	NO		OF DEATH?
	DID TOBACCO U	SE CONT	RIBUTE TO CA	USE OF D	EATH Y	ES 🗆	ΝΟ Γ	7 UNG	FRTAIN					1 YES 2 NO
NA.	25, WAS CASE REFERRED TO				PLACE OF DEA					, , ,				
Sic	1 TYES 2 NO		HOSPITAL:	ER/Outpetler	nt 3 🗆 DOA	OTHEI		ne 5 🗆 R	ealdence	6 Other (S	Specifyl			
PHYSICIAN:	27. MANNER OF DEATN 1 Natural 5	Pending	26a. DATE OF (Month, D	INJURY ay, Year)	26b. TIN	IE OF JURY	W	JURY AT	740	26d. DESCR	IBE NOW I	NJURY OC	CURED	
D BY	2 Sulaida	Investigation Could not be	26a. PLACE O	F INJURY — A	At home, farm,	etreet, fact		YES 2	_ NO			nd Number	r or Rural R	loute Number,
COMPLETED		determined	ounding,	atc. (Specify)						City or	Town, State)			
PL			ICIAN: To the best of											
Sol	one) 2 MEDI	ICAL EXAMINE	R: On the basis of a	xamination and	d/or investigation	on, in my o	opinion,	death occu	red at the	time, data an	d place, and	d dua to th	he couse(a)) and manner as stated.
BE (296. SUGMATURE AND STILE		200					29c. LIC	ENSE NUM	IBER		29d. DAT	E SIGNED	(Month, Day, Year)
5	30. NAME AND ADDRESS OF	DEDGON WH	O DOMBI ETEO COM	DE OF CTAT	ATEM CT. CT.	0.4.2		14	すりと	011		•	101	1) 19(
	Statt Sw	een e	en DO	112	20	BeA	NOI	Par	P	Pol	Bon	12	MB	21811
	31, DATE FILED (Month, Day,	Year)	Jalen du	R'S SIGNATU	ordall.									
	OCT 1	7 1995	Jan au	AND THE PERSON NO.	Car Colone									

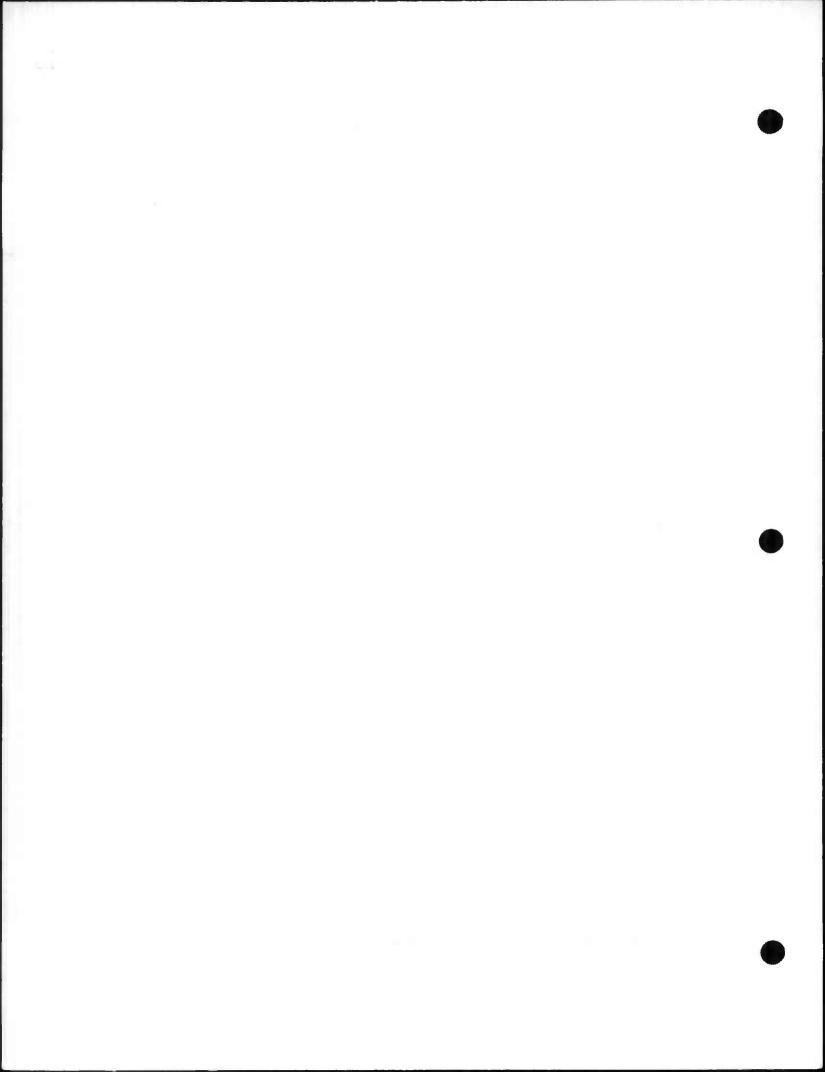
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		1 - STATE REGISTRAR	STATE OF MARYL	AND / DEF	'ARTMENT 'IFICATE	OF DEATH	ND MENT	TAL HYGIEN REG. NO.					
		1. OECEDENT'S NAME (First, Middle, Last) Marquerite Virginia 4. SOCIAL SECURITY NUMBER			Hoi	Ibrook	Oc.		0 199	S C	TIME OF DEATH		
Pi		216-18-2256	1 □ M 2 🔀 F	(In yrs. lest birthd	IS. MONTHS	DAYS HOURS I	MIN. Ma	rch 14,	1915 N	(Country)			
3 should	E E	8a. FACILITY NAME (if not institution, give str		סשימונים		TOWN OR LOCATION	OF DEATH		9c. COUNTY				
5 1, 2,	DIRECTOR	PENINSULA REGIONA RESIDENCE OF DECEDENT 100. STATE 100. COUNTY				ALISBURY			MTC	OMIC			
L. Pages	DIRE		nerset		. city, town on rincess						d. INSIDE CITY LIMITS? YES 2 NO		
permit.	ERAL	10e. STREET AND NUMBER				101. ZIP CODE				N OF WHA	T COUNTRY?		
020 physician. burlal-transit	FUNER	13728 Bobtown Road	12. WAS DECEOENT EVER I	************	T 40 W	2185			USA				
215-0020 attending physician. use as the burial-tran	BY	1 Never Married 2 Married 3 XWidowed 4 Divorced	FORCES? 1 YES	2 X NO	If :	MS DECENDENT OF I yes, specify Cuban, ii YES 2X NO	Maxican, Puer	GIN? (Specify Yes to Rican, etc.)		Black, W Specify:	American Indian, hita, atc.		
	TED	15. DECEDENT'S EDUC. (Specify only highest grade of	completed)	(Give kind	NT'S USUAL OCC d of work done du OT use retired.)	CUPATION uring most of working	The state of the s	166. KIND OF BUS					
AND 21 the hospital or detached for u	once.	Elementary/Secondary (0-12) 11th grade	College (1-4 or 8+)		,	Contractor	r :	Somerse	t Co. E	3oarc	of Ed.		
	COM	17. FATHER'S NAME (First, Middle, Last)						st, Middle, Maiden					
MARYL retained by 5 should be	BE	William J. H. Burke	<u> </u>	T 19b. MAII	ING ADORESS	(Street and Number or		Mitchel					
S 5 10	TO BI	Wendell Holbrook				Avenue -					07302		
e do m	MUST	20a. METHOD OF DISPOSITION 1. Burlet 2 Cremetion 3 Remort 4 Donation 5 Other (Specify)	wal from State 20t	b. PLACE AND DA	Church	Cemetery	y 10		cation - ch				
ALTIM Seath. Page funeral direc	examiner	Strict 2 Cremetton 3 Removal from State Surface 2 Cremetton 3 Removal from State Strict Paul Church Cemetery 10/16 Mt. Vernon, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSES 22. NAME AND ADDRESS OF FACILITY Jolley Memorial Chapel											
		1213 Jersey Road - Salisbury, Md 21801											
within 24 upletely fill cremation,	event, the medical	ahock, or heert fellure. L IMMEDIATE CAUSE (Final disease or condition resulting in death)	omplications that cause clist only one cause on e	diac		he mode of dying hy Kne hy Dise		ardiac or reapli	retory arreat	•	Approximate Interval Between Onset and Death		
	- 1	Sequentially list conditions, 6.				5 yrs.							
ior in the Co		If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	A ZA RO) OT 3UG	7	/	5.5							
Certificate ding physiene pr	RTIF	that initiated events resulting in death) LAST	DUE TO (OR AS A	A CONSEQUENCE	E OF):								
- # = =		PART II Other elgolificant conditions	contribution telidenth I		- u la sha und		1. Pad I	T					
the that I	티얼	- aus	Pelmon a		1	the underlying ceuse given in Part I. 24a. WAS AN AUTOF PERFORMED?					AVAILABLE PRIOR TO COMPLETION OF CAUSE		
Te Se E	ME	- Chroni	- Rent	1 Fa	eleve			, , , , , ,			DEATH? YES 2 NO		
has b	AN:	DID TOBACCO USE CONTR			YES No		RTAIN						
_ F 2 % ;	PHYSICIAN:	EXAMINER?	HOSPITAL:		OTHER:	ny one) : ng Home 5 🗆 Raside	lence 8 0	ther (Specify)					
THYSICE his cert with the	PHY:	27. MANNER OF DEATH	28a. OATE OF INJURY (Month, Day, Year)		TIME OF 2	8c. INJURY AT WORK?	28d. C	DESCRIBE HOW IN	JURY OCCUR	ΙΕΟ			
After ti	BY P	2 Accident Investigation	28e. PLACE OF INJURY	f — At home, far		1 YES 2 N		OCATION (Street as	and Number or i	Pural Route	Number		
S at a se at a		4 Homicide datarmined	building, etc. (Spec	cify)			C	City or Town, State)			1707-1004		
A A Z	COMPLETE		CIAN: To the best of my know										
HOSPI FUNER within	00	2 MEDICAL EXAMINER 29b. SIGNATURE AND TALLE OF CERTIFIER	3: On the beals of examination	n and/or Investig	etion, in my opi			eta and place, and					
THE THE Se filed	BE C	Bout	S. /2	an a	n	29c, LICENS	-100	50	29d. DATE SI	GNED MO	nth, Day, Year)		
	2	30. NAME AND AGORESS OF PERSON WHO	COMPLETEO CAUSE OF DE	ATH (ITEM 27) (7	Type, Print)	47-0 R	Land)	1. Dr	- You	11	MAZIE		
la		31. DATE FILED (Month, Day, Year) OCT 13 1995	32 REGISTRAR'S SIGN	x-hardell)			

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1 - STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

		REGISTRAR		CERTIF	TCATE U	FUEATH	REG. NO).						
		1. DECEDENT'S NAME (First, Middle, Las	*				2. DATE OF DEATH	DAY O XE	3. TIME OF OEATH					
		John W. Heff					10 21 b	9 5°	4:55 A M					
		4. SOCIAL SECURITY NUMBER		GE (In yrs. lest birthday)			7. DATE OF BIRTH		BIRTHPLACE (State or Foreign					
-		411-10-8714	1 N 2 F	8.1 YRS.	MONTHS DAYS	B HOURS MIN.	(Month, Day, Year) 2-21-14		Country)					
should		9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH												
2, 3 s	la B	Anne Arundel Med. Ctr. Annapolis Anne A												
₩.	5	RESIDENCE OF DECEDENT				KIIII	e Arunuer							
Sage	DIRECTOR	10e. STATE 10b. COUN			TY, TOWN OR LOC				10d. INSIDE CITY LIMITS?					
permit. Pages			ne Arundel	Mi	llersv	ville			1 TES 2 NO					
	FUNERAL	10e. STREET AND NUMBER				10f. ZIP CODE		10g. CITIZEN	OF WHAT COUNTRY?					
199		705 Doages Dri	ive			21108		USA						
215-0020 attending physician. se as the burial-transit	5	11. MARITAL STATUS	12. WAS DECEOENT EVER		13. WAS 0	ECENDENT OF HISPAN	NIC ORIGIN? (Specify Yes	s or No 14, F	RACE — American Indian,					
02 Pur		1 Never Married 2 Married	FORCES? 17 YES		If yes,	specify Cuban, Mexico (ES 2 JNO Specify	en, Puerto Rican, etc.)		Black, White, etc. Specify:					
ending as the	ВУ	3 Widowed 4 Divorced	WWII				,	,	White					
aften use a	윤	15. DECEDENT'S ED (Specify only highest gra	DUCATION ade completed)	16e. DECEDENT'S	USUAL OCCUPY	ATION	16b, KIND OF BUS	SINESS/INDUSTI						
21 or u		Elementary/Secondary (0-12)	College (1-4 or 5+)	ille. Do NOT u	work done during a use retired.)	most of working								
thed its	AP.	1.2		Linot	vne Or	perator	Print	ing Co						
the hospital detached to	COMPL	17, FATHER'S NAME (First, Middle, Last)			A Tree Mar		ME (First, Middle, Maiden							
Z be a	BE C	John	Heffe	ernan		Mary	Virginia							
MARYLAND 21215-0020 retained by the hospital or attending physics 5 should be detached for use as the burial notified at once.		19a. INFORMANT'S NAME (Type/Print)		196. MAILING	G ADDRESS (Street		Route Number, City or Tow		(a)					
M reta	임	John C. Colli	ine				Millersvi							
ALTIMORE, death. Page 6 may be tuneral director, page i. examiner must be		20s. METHOD OF DISPOSITION	20	206. PLACE AND DATE				CATION - City o						
ALTIMOR leath. Page 6 ma funeral director, p		1 Suriel 2 Cremation 3 Re 4 Donation TOOther (Specify)	emoval from State	cemetery, cremetory or o	other plece)		1							
ALTIMO death. Page 6 funeral directo		21. SIGNATURE OF FUNERAL SERVICE-	ARTHUSEE	Maplewo		netery 1		ris, T	n.					
ath. I		Barranco & Sons Funeral Home												
BA Ber des Wal.		marin	Janus						ome ark MD21146					
# ≥ £ 5		23. PART 1. Enter the diseases, or	r complications that ceus	sed the death. Do	not enter tha r	node of dying, suc	h as cardlec or reap	iratory arrest,	Approximata					
		shock, or haert fallure IMMEDIATE CAUSE (Final	re. Liat only one cause on	aech lina.				THE PARTY OF THE P	Interval Between Onset and Death					
i z4 ho iy filled ation, o		disease or condition												
d within 24 ompletely fill cremation, the event, the		reaulting in death)	B DUE TO (OR A!	S A CONSEQUENCE OF					Sdays					
	_	_		, , , , , , , , , , , , , , , , , , , ,	rj.									
executed and control burial, mattic e	Ó	Sequentially list conditions,	b DUE TO (OR A!	A CONSPOUENCE O	NE).									
or t or	Ä	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in deeth) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. OUE TO (OR AS A CONSEQUENCE OF): d												
Fe physical Delay	Fic													
	Ē													
_ = = =	E		_ d											
		PART II. Other aignificant condition	ons contributing to death	but not resulting	In the underly	ing cause given in			24b. WERE AUTOPSY FINDINGS					
ORD; that the led by the th and M any Inju	EDICAL		COPU				PERFOR	1	AVAILABLE PRIOR TO COMPLETION OF CAUSE					
Sign Sign	밀		Bladder C	A				NO	OF DEATH?					
w requ	Σ.	DID TOBACCO USE CON			ON El 22	UNCERTAIN	 .	- 1	1 YES 2 NO					
AL F he law has be be Dept. n 23 s	AN	25. WAS CASE REFERRED TO MEDICAL	TRIBUTE TO CAUSE .	26. PLACE OF DEAT	/		4 🗆 📗							
	SICIAN:	EXAMINER?	HOSPITAL:		OTHER:		at the same							
F VIT SICIAN: The certificate the State t, or Iter	17S	27. MANNER OF DEATH	1 Inpetient 2 ER/Out			ome 5 Residence								
NG PHYSIC feer this ce sath with the marked,	РНҮ	1 Netural 5 Pending	(Month, Day, Year)		JURY Y	NJURY AT WORK?	26d. DEŞCRIBE HOW II	NJURY OCCURE	D					
After the death death	B√	2 Accident Investigation				YES 2 NO								
TTENDING TOR: After after death 28 Is man	ED	3 Suicide 8 Could not be	muliding, etc. (Soi	RY — At home, farm, a pecify)	street, fectory, off	fice	281. LOCATION (Street e City or Town, Stete)	and Number of Ru	iral Route Number,					
DR ATTEN DIRECTOR: hours after item 28 ls		4 Homicide determined												
	COMPLET	29e. CERTIFIER CHOCK only 1 CERTIFYING PHY	YSICIAN: To the best of my know	owledge, death occurr	ed at the time, dr	ate end place, end due	to the cause(s) end mar	nner se stated.						
THE HOSPITAL THE FUNERAL filed within 72 PORTANT: If	NO.		INER: On the basis of axamination						use(s) and manner se stated,					
HOSPI FUNEF within TTANT:		296. SIGNATURE AND TITLE OF CERTIFI		77										
TO THE HOSPI TO THE FUNER De filed within	H	Strant &	Loloull	Lillo		29c. LICENSE NUM	ABER	29d, DATE SIGI	NED (Month, Day, Year)					
₽ ₽ ≥ ₹	2	30. NAME AND ADDRESS OF PERSON W	TO COMM EVED CAMES OF I	5,000		01180	, 8	10	12414)					
		CHINIT F	OLOLA CA	GATH (ITEM 27) (Type,	Print)	001 -	#ONN A	Mnapol	is. lud. 21401					
		STUUVI LI 3	Elovicor	700 00	Trans	E rui -	# SUU /	Hirapol	15, ma. 2001					
		31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIG	char Randell										
_		OCT 26 199		1 2 1										



BALTIMORE, MARYLAND 21215-0020

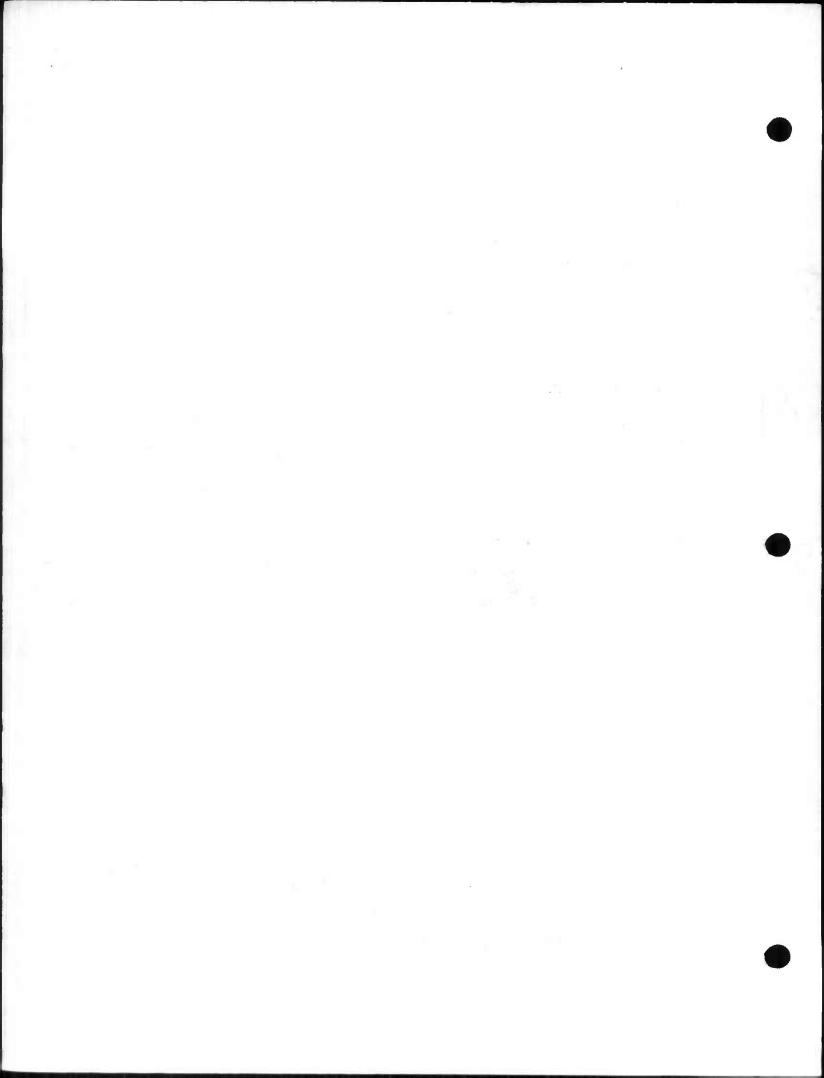
DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	FOR 1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPAR					ENTAL HYGIEN	E		
	1, DECEDENT'S NAME (First, Middle, Last)						-	2. DATE OF DEATH			3. TIME OF DEATH
	ANEAL HI	LL						OCT. 23 19		YEAR	7:20 AM M
	4. SOCIAL SECURITY NUMBER		in yrs. last birthday)	IF UNDER	1 YEAR	IF UNDER	24 HRS.	7. DATE OF BIRTH (Month, Day, Year)		8. BIRTHI Country	PLACE (State or Foreign
	220-36-8347		4 YRS.	MONTHS	UATS	HOURS		OCT. 5 194		NEW	YORK
~	9e. FACILITY NAME (If not institution, give str	eet and number)		9b. CITY,	, TOWN O	R LOCATIO	ON OF DEAT	гн	9c. COU	NTY OF DE	АТН
DIRECTOR	ANNE ARIINDEL MEDI	CAL CENTER		ANN	APOI	IS			ANN	VE AR	UNDEL
EC	10a, STATE tob. COUNTY	-	10c. CI7	Y, TOWN C	R LOCAT	ION					10d. INSIDE CITY LIMITS?
	MARYLAND ANNE	ARIINDEI.	ANI	NAPOL	IS						t X YES 2 NO
₹AL	10e. STREET AND NUMBER				101	. ZIP CODE			. 30	IZEN OF W	HAT COUNTRY?
FUNERAL	237 ADMIRAL DRIV				\perp		401		USA		
	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT EVER IF	2 NO		If yes, sp	ecify Cubar	n, Mexican,	ORIGIN? (Specify Yea Puerto Rican, etc.)	or No-	14. RACE Black	American Indian, White, atc.
ВҰ	3 Widowed 4 Divorced	1959 - 19			1 🗌 YES	2 XNO	Specify:			BLA	ČК
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade of		16a. DECEDENT'S	USUAL O	CCUPATIO	ON et of workin		16b. KIND OF BUS	INESS/IN	DUSTRY	
	Elementary/Secondary (0-12)	College (1-4 or 5+)	AIR CRA	se retired.)			9	U.S. AII	R FOE	RCE	
MP	12th	0	TECHNIC								
	t7. FATHER'S NAME (First, Middle, Last)	_						E (First, Middle, Maiden	Sumame)		
BE	RICHARD B. HIL 19a, INFORMANT'S NAME (Type/Print)	<u>L</u>		1 1000000			Y EAI	UES ute Number, City or Towi			
2	GLORIA HILL							POLIS, MD			
	20s. METHOD OF DISPOSITION	206	PLACE AND DATE				ANNA		_	City or Tox	wn. State
	1 Donation 5 Other (Specify)	val from State	RYLAND	VETER	RAN (CEMET	ERY	10/27/95	CROWN	NSVIL	LE, MD.
	21. SIGNATURE OF FUNERAL SERVICE LICE	ENSEE		22.	NAME AN	D ADDRES	S OF FACI	LITY			
	Harry 1.	7. Lee.	20					ORTUARY,		21/.0	1
	23. PART I. Enter the diseases, or co	omplications that cause	the death. Do					NNAPOLIS,			Approximate
	ahock, or heart fallure. L IMMEDIATE CAUSE (Final		1 0	1							Interval Between Onget and Death
	disease or condition resulting in death)	intraces	May	ne	mo	Mh	ees				1 5 days
		MITALERO DUE TO GOR AS A	CONSEQUENCE	F):			0				20 115
NO	Sequentially list conditions,	fulfatture as	CONSEQUENCE O	F):							90401
ξ	If any, leading to immediate cause. Enter UNDERLYING	ADDIN		. ,.							120 yr
Ħ	CAUSE (Diseese or injury that initiated events	DUE TO (OR AS A	CONSEQUENCE C	F):							
CERTIFICATION	resulting in death) LAST	l							_		
	PART II. Other algnificent conditions	contributing to death b	ut not resulting	in the un	derivine	2 Ceuse C	iíven in P	ert I. 24e. WAS AN	ALITOPSY	24b.	WERE AUTOPSY FINDINGS
PHYSICIAN: MEDICAL					,	9 3	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	PERFOR	MED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE
								1 YES 2	NO NO		OF DEATH?
2	DID TOBACCO USE CONTR	RIBUTE TO CAUSE O	F DEATH Y	ES 🔲 I	NO [UNC	ERTAIN	文			1 123 2 1 110
NA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEA	TH (Check	only one)						
SIC	1 TES 2 NO	HOSPITAL:	patient 3 🗆 DOA	4 Nur		e 5 🗆 Re	aldence 8	Other (Specify)			
PH	27. MANNER OF DEATH 1 September 1 Septemb	28e. DATE OF INJURY (Month, Day, Year)	28b. TIR	ME OF JURY	28c. INJ WO	URY AT	1	28d. DEŞCRIBE HOW II	NJURY OC	CURED	
ВУ	1 Natural 5 Pending 2 Accident Investigation			М		YES 2					
E	3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF INJURY building, etc. (Spec	— At home, ferm,	atreet, taci	lory, offic	•	1	28t. LOCATION (Street a City or Town, Stete)	and Numbe	er or Rumi R	toute Number,
	29a, CERTIFIER								_	_	
COMPLETED	opel	CIAN: To the best of my know CIAN: On the beste of exemination									end manner as steted.
	29b. SIGNATURE AND TITLE OF CENTIMEN) ,					NSE NUMB				(Month, Pipe Year)
B	Malle	Devit 1	d			MAG	7 104	<u> </u>	▶ (0/2	Polli
유	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DE	ATH (ITEM 27) (Type	Print)		2)07	177	4		10	010
1	Jack/Lichte	2NSTEIN	2011	Ridg	/e>	1	he.	ANNO	1.1	1d. 6	21401
	31. DATE FILED (Month, Day, Yeer)	32. REGISTRAR'S SIGN	On a designation of	-	1		-				
	OCT 2 6 199	5 This Store	Leon Rendal								



95 33668

95-6511-025

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after	law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FIREDAL DIDEPTION. Above this confidence has been sized by the obtaining sharings and completely filed in by (has furnished disconting and a chould be determined for use one on the huntry terrange around Deman 4 to a should
IN THE FUNE ALL DIRECTORS ATTRACTORS ATTRACTORS THIS CERTIFICIAL STATE OF THE STATE	the luthered billection, page 3 should be betached for use as the burlat-trained per ill. Tayles 1, 2, 3 should
be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	
	the second secon
IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	examiner must be notified at once.
CONTRACTOR OF THE CONTRACTOR O	

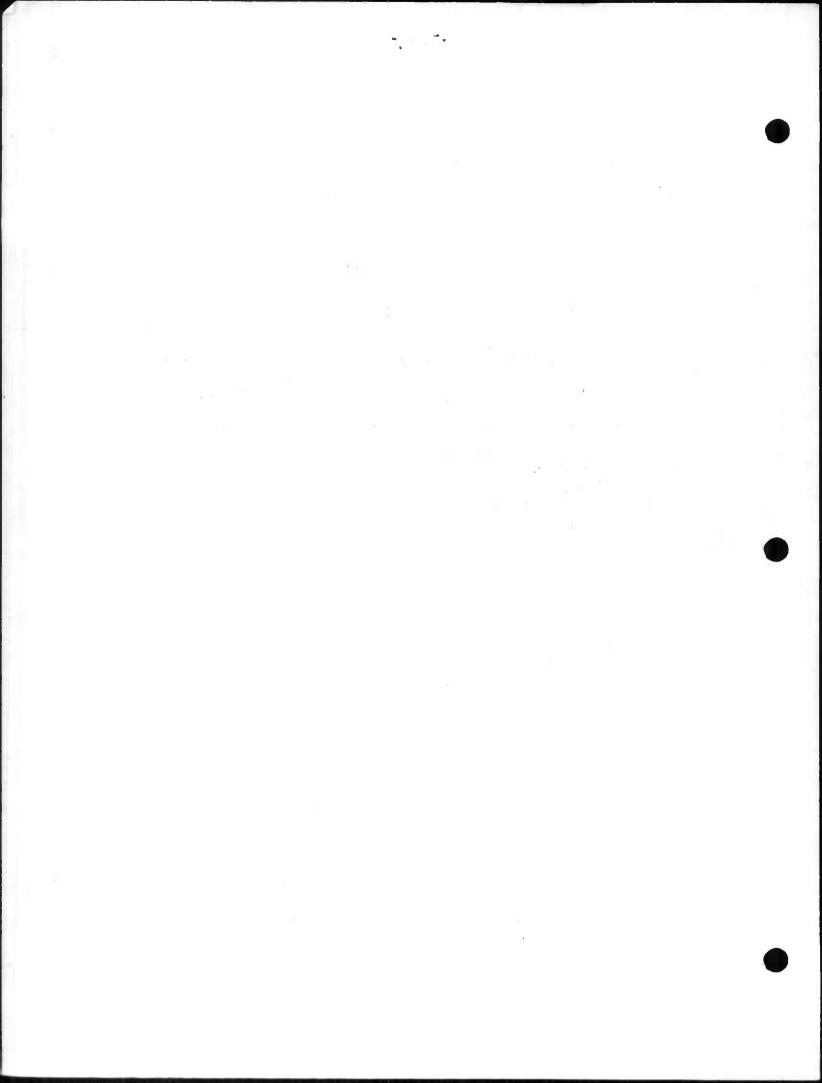
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

ITEMS: 23 PART I, II	, 27, 28a-f, PER M	EO FILM G	-729 11,	/17/95 t.	t		00000				
1 - FOR STATE REGISTRAR					MENTAL HYGIEN REG. NO	E					
1. DECEDENT'S NAME (First, Middle, Last) SANDRA	LYNN	HILB	ECK		2. DATE OF DEATH OCT . 24,	199	3. TIME OF DEATH 3:15 P. M				
218-52-2698	□ M 2 🔀 F 48	YRS. MONTH	DAYS H	DURS MIN.		BIRTHPLACE (State or Foreign Country) Saryland					
90. FACILITY NAME (If not institution, give street 200 S. POST RD. RESIDENCE OF DECEDENT	and number)				ATH	ec. COUNTY OF DEATH Harford					
	Harford			ı			10d. WSIDE CITY LIMITS? 1 X YES 2 NO				
309 South Parke St			. 2	1001	4,000	U.S	N OF WHAT COUNTRY?				
1. MARHIAL SIATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	FORCES? 1 YES 2 N IF YES, GIVE WAR OR DATES	MED 1	it yes, specif	y Cuban, Maxicar	n, Puarto Rican, etc.)		4. RACE — American Indian, Black, Whita, atc. Specify: Thite				
(Specify only highest grade com	npleted) (Gir	ve kind of work dor	e during most o	f working	16b. KIND OF BU						
12 17. FATHER'S NAME (First, Middle, Last)	0 Ho	memaker		MOTHER'S NAI							
Earl Ashenfelter					- (Gurierney					
19a, INFORMANT'S NAME (Type/Print)											
Burlet 2 Cremetton 3 Removat from State Cemetery, crematory or other place) 4 Donatton 5 Other (Specify) Baker Cemetery 10/28 Aberdeen, Maryland											
21. SIGNATURE OF FUNERAL SERVICE LICENSES 22. NAME AND ADDRESS OF FACILITY TARRING-CARGO FUNERAL HOME, 333 S. PARKE ST. ABERDEEN, MD. 21001-3399											
23. PART I. Enter the diseases, or com ahock, or heart failure. List	as cardiac or reap	ratory arres	Approximate								
iMMEDIATE CAUSE (Finei disease or condition reaulting in death)	HYPOTHERMIA					•	Onset and Death				
DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):											
Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury											
that initisted eventa resulting in death) LAST	DUE TO (OR AS A CONSEC	DUENCE OF):									
PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part i. MYOCARDITIS 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO											
				UNCERTAIN	10		1 _ YE\$ 2 _ NO				
EXAMINER?	OSPITAL:	OTH	ER:	5 Residence	X Other (Specify)	TN WO	OODS				
27. MANNER OF DEATH 1 Netural 5 Pending	28a. DATE OF INJURY (Month, Day, Year) FOUND: 10-24-95	FOUNDURY 11:11 A4	28c. INJURY WORK	Y AT	eXI Other (Specify) IN WOODS 28d. DESCRIBE HOW INJURY OCCURED SUBJECT EXPOSED TO WEATHER						
3 Suicide 6 Could not be 4 Homicide detarmined	building, etc. (Specify)				281. LOCATION (Street City or Yown, State) ABERDEEN, M	(Street and Number or Rural Route Number, n. State) 200 S. POST ROAD					
29a. CERTIFIER (Check only one) 2 X MEDICAL EXAMINER: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(a) and manner as stated.											
296. SIGNATURE AND TITLE OF CERTIFIER The term of the second of the sec	" Ky m	0					SIGNED (Month, Day, Year) 1. 25, 1995				
	1. DECEDENT'S NAME (First, Middle, Last) SAND RA 4. SOCIAL SECURITY NUMBER 218-52-2698 9a. FACILITY NAME (If not institution, give street 200 S. POST RD. RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY Maryland 10c. STREET AND NUMBER 309 SOUTH PARKE St 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced 15. DECEDENT'S EDUCATY (Specify only highest grade come in the state of the	TOR STATE STATE STATE REGISTRAR 1. DECEDENT'S NAME (First, Middle, Last) SANDRA 4. SOCIAL SECURITY NUMBER 218—52—2698 Se. FACILITY NAME (If not institution, give street and number) 200 S. POST RD. RESIDENCE OF DECEDENT 100. STATE 100. STATE 100. STATE 100. STATE 100. STATE 11. MARYLAND 12. WAS DECEDENT SERVE UNIVERSED 13. Widowed 4 Divorced 14. Divorced 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16. DEFENDANT'S NAME (First, Middle, Last) FART AShenfelter 196. BYFORMANT'S NAME (First, Middle, Last) FART AShenfelter 196. BYFORMANT'S NAME (First, Middle, Last) FART AShenfelter 197. BYFORMANT'S NAME (First, Middle, Last) FART AShenfelter 198. BYFORMANT'S NAME (First, Middle, Last) FART I. Enter tip diseases, or complicetions that caused the de shock, by heart failure. List only one cause on each line immediate cause. Enter UNDERLYING ALL SAMMEDIATE CAUSE (Fined disease or condition resulting in death) ADUE TO (OR AS A CONSECT	STATE CERTIFICAT DECEDENTS AMBE (First, Micdole, Last) SANDRA LYNN HILB 4. SOCIAL SECURITY NUMBER 218-52-2698 1	TORCEDENT'S NAME (First, Micross, Last) SANDRA LYNN HILBECK 4. SOCIAL SECURITY NAMER 2. SCALL SECURITY NAMER 3. SCALL SECURITY NAMER 4. SOCIAL SECURITY NAMER 5. SCALL SECURITY NAMER	TOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND M CERTIFICATE OF DEATH 1. DECEDENT NAME (First, Models, Last) SANDRA 4. SOCIAL SECURITY NUMBER 218-52-2698 5. SEX 218-52-2698 5. MAY RE 3. AGE (in yrs. Inst birmology) 200 S. POST RD. ABERDEEN 5. MAY RE 48 YRS. 6. AGE (in yrs. Inst birmology) 200 S. POST RD. ABERDEEN 6. AGE (in yrs. Inst birmology) 200 S. POST RD. ABERDEEN 6. AGE (in yrs. Inst birmology) 200 S. POST RD. ABERDEEN 6. AGE (in yrs. Inst birmology) 200 S. POST RD. ABERDEEN 6. AGE (in yrs. Inst birmology) 200 S. POST RD. ABERDEEN 6. AGE (in yrs. Inst birmology) 200 S. POST RD. ABERDEEN 6. AGE (in yrs. Inst birmology) 200 S. POST RD. ABERDEEN 6. AGE (in yrs. Inst birmology) 200 S. POST RD. ABERDEEN 6. AGE (in yrs. Inst birmology) 200 S. POST RD. ABERDEEN 6. AGE (in yrs. Inst birmology) 200 S. POST RD. ABERDEEN 6. AGE (in yrs. Inst birmology) 200 S. POST RD. ABERDEEN 6. AGE (in yrs. Inst birmology) 200 S. POST RD. ABERDEEN 6. AGE (in yrs. Inst birmology) 200 S. POST RD. ABERDEEN 6. AGE (in yrs. Inst birmology) 200 S. POST RD. ABERDEEN 6. AGE (in yrs. Inst birmology) 200 S. POST RD. ABERDEEN 6. AGE (in yrs. Inst birmology) 200 S. AGE (in yrs. Inst birmology) 201 S. AGE (in yrs. Inst birmology) 202 S. AGE (in yrs. Inst birmology) 203 SOUTH Parks 7. AGE (in yrs. Inst birmology) 204 S. AGE (in yrs. Inst birmology) 205 SOUTH Parks 7. AGE (in yrs. Inst birmology) 206 S. AGE (in yrs. Inst birmology) 207 S. AGE (in yrs. Inst birmology) 208 SOUTH Parks 7. AGE (in yrs. Inst birmology) 208 SOUTH Parks 7. AGE (in yrs. Inst birmology) 208 SOUTH Parks 7. AGE (in yrs. Inst birmology) 208 SOUTH Parks 7. AGE (in yrs. Inst birmology) 21 SOUTH SEQUENT SEQUEN	DECEDENT NAME (First, Modes, Last) SANDRA LYNN A. BOCAL SECURITY NUMBER 3. BET ASE OF DEATH A. BOCAL SECURITY NUMBER 218 – 5.2 – 2698 3. DATE of DEATH A. BOCAL SECURITY NUMBER 3. BET OF DEATH A. BOCAL SECURITY NUMBER 3. BET OF DEATH A. BOCAL SECURITY NUMBER 3. BET OF DEATH A. BOCAL SECURITY NUMBER 3. BET OF DEATH ABERDEECE 4. BOCAL SECURITY 3. BATTE OF DEATH ABERDEECE 4. BOCAL SECURITY 3. BATTE 3. BATTE OF DEATH ABERDEECE 4. BOCAL SECURITY 3. BATTE 3. BATTE OF DEATH ABERDEECE 4. BOCAL SECURITY 3. BATTE 3. BATTE 3. BATTE 3. BATTE 4. BOCAL SECURITY 3. BATTE 3. BATTE 3. BATTE 4. BOCAL SECURITY 3. BATTE 3. BATTE 3. BATTE 3. BATTE 4. BOCAL SECURITY 4. BATTEL STATUS 1. BARATHA, STATUS 1. BARATHA, STATUS 1. BARATHA, STATUS 1. BARATHA, STATUS 1. BARATHA, STATUS 1. BARTHA,	DECEMBER 1 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE RECOGNITION DECEMBER 1 SME (First, Moon, Last) SANDRA LYNN HILBECK 2.0.04. SEQUENT HUMBER 2.18-52-2698 1.				

31. DATE FILED (Month, Day, Year)
OCT 27 1995

111 Penn Street, Baltimore, Maryland 21201



68760	
BOX	
P.O.	
RECORDS,	
OF VITAL	
INISION	

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First Middle Last) 3. TIME OF DEATH 2. DATE OF DEATH JOSIE MAE HOWELL 1995 10 25 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTNPLACE (State or Foreign Country) 1 M 2XX 213-60-6516 May 10,1908 Virginia 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATN DIRECTOR use as the burial-transit permit. Pages 1, 2, 3 Harford Memorial Hospital Havre de Grace Harford 10b, COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Harford Bel Air 1 YES 2 X NO FUNERAL 10a. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 1226 Prospect Mill Road 21015 U.S.A. ay be retained by the hospital or attending physician, page 5 should be detached for use as the burial-tran 11. MARITAL STATUS 12. WAS OECEDENT EVER IN U.S. ARMED FORCES? 1 TYES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married If yes, specify Cuban, Maxican, Puarto Rican, atc.) 1 TES 2 NO BY Specify: 3 Widowed 4 Divorced Specify White COMPLETED 15. DECEDENT'S EQUICATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KING OF BUSINESS/INDUSTRY (Specify only high Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker In Home 17. FATHER'S NAME (First, Middle, Lest) 16. MOTHER'S NAME (First, Middle, Maiden Surname) Ti Richard Emmert BE Ollie Henry notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING AODRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 0 Mr. Virgil Osborne, Jr. 1226 Prospect Mill Road, Bel Air, Maryland 21015 hours after death. Page 6 may be must be 20a. METHOD OF DISPOSITION

1 Strict Burlel 2 Cremetion 3 C

4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE funeral director, Harford Memorial Gardens 10/28 Aberdeen, Maryland examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Tarring-Cargo Funeral Home, P.A. wax Aberdeen, Maryland 21001-3399 filled in by the fion, or removal. the medical 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory erreat, abock, or heart fellure. List only one cause on each line. Interval Between cremation, or **IMMEDIATE CAUSE (Finel** Onset and Death Myocardial Injarct disesse or condition resulting in death) completely One wee traumatic event, DUE TO (OR AS A CONSEQUENCE OF) executed Hygiene prior to burial, Ongestive hears
DUE TO OR AS A CONSEQUENCE OF): and Sequentially list conditions. if any, leading to immediate attending physician 8 Hypertensian cause. Enter UNDERLYING death certificate CAUSE (Disease or injury other OVE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 70 arrythmis Menta of Health and Men PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part i. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE that shows any) ementia 1 TYES 2 NO requires OF DEATH? 1 YES 2 NO peen DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: S.W 23 this certificate has with the State Dep 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Item HOSPITAL: PHYSICIAN: 1 TYES 2 NO Inpetient 2 - ER/Outpetient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 26b. TIME OF 26c. INJURY AT WORK? 28a. DATE OF INJURY (Month, Day, Year) 28d. DESCRIBE NOW INJURY OCCURED marked, 1 Netural 5 Pending 1 YES 2 NO THE HOSPITAL OR ATTENDING F THE FUNERAL DIRECTOR: After I filed within 72 hours after death BY 2 Accident 26s. PLACE OF INJURY — At home, lerm, street, factory, office building, atc. (Specify) 3 Sulcide 28 18 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 4 Nomicide Item 29e. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data end place, and due to the cause(a) end manner as stated. TO THE FUNERAL IDE filed within 72 h 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER BE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) hy sician 10-26-95 043113 2 OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 30 NAME AND ADD DIRZA

DHMH-16 Rev 1/89

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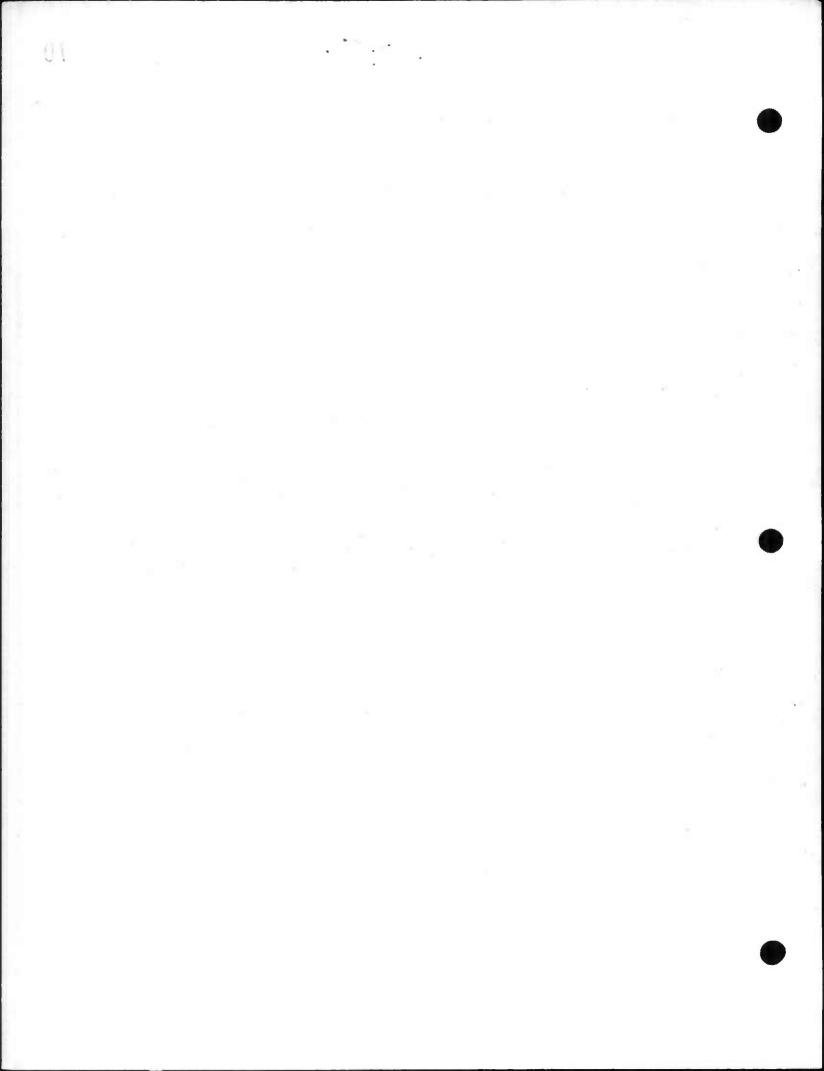
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 12 burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEDENT'S NAME (First, I	Middle, Last)	FRANKLIN						2. DATE OF				3. TIME OF DEATH	
	Willian	WWW	Ho	2050.	\wedge			October 22 199			YEAR	2:26 04		
	4. SOCIAL SECURITY NUMBER	R	5. SEX	6. AGE (In yrs.		IF UNDER 1	EAR IF U	AR IF UNDER 24 HRS.		BIRTH		a. BIRTHPLACE (State or Foreign		
	215-14-4848		1 M 2 F	76	YRS.	MONTHS	AYS HOU	RS MIN.		(Month, Day, Year) Country			ry)	
	9a. FACILITY NAME (If not inst	titution, give s	treet and number)	/0		9b. CITY. T	OWN OR LOC	ATION OF D	Oct. 22, 1919				ryland	
ECTOR	Harford Me	emoria		al	1 9	9b. CITY, TOWN OR LOCATION OF DEATH Havre de Grace					9c. COUNTY OF DEATH Harford			
5	RESIDENCE OF DECE	v												
DIR.		10b. COUNT			10c. C11	Y, TOWN OR						10d. INSIDE CITY LIMITS?		
	Maryland 100, STREET AND NUMBER	1	larford			Chu	rchvi						1 YES 2 X NO	
FUNERAL											10g. CITI	ZEN OF V	WHAT COUNTRY?	
빌	3003 Whitef	rield						21028			USA	1		
5	11. MARITAL STATUS 1 Never Married 2 N	ferried	12. WAS DECEDEN	T EVER IN U.S.		13. WA	S DECENDER	T OF HISPA	NIC ORIGIN? (S	Specify Yes	or No-	14. RACE Black	E — American Indian, k, White, atc.	
₽	3 Widowed 4 Divorce		IF YES, GIVE Y	- 197	0			NO Specif		, 5.6.,		Speci	My:	
60	16 DECEI	DENT'S EDU											White	
	(Specify only i	highest grade	completed)		(Give kind of a life. Do NOT us	work done dur	IPATION ng most of w	orking	16b. KJ	NO OF BUS	SINESS/IND	USTRY		
once. COMPLET	Elementary/Secondary (0-1	(2)	College (1-4 or 5	·)			7			-				
S S	17. FATHER'S NAME (First, Mid	Idle faet			Insu	rance					nsura	ance		
- Compa			·						ME (First, Midd					
B B	Raymond Fo		lanson	-					Eliz					
들은									Route Number,					
9	Emily M. Ha							Rd.,	Churc	hvil:	Le. M	d. 2	1028	
5	20e. METHOD OF DISPOSITIO	3 🗆 Reme	oval from State		CE AND DATE O		N (Name of		DATE	20c. LO	CATION —	City or To	wn, State	
E	4 Donetion 5 Other (S		and a	R.A	. Ferr	is &				W.	Che	ster	, Pa.	
Ē	21. SIGNALIME LIP FUNERAL	111	TIMO	1				MarCu		TT T.		7 77-		
	Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, Md. 21009												me, P.A.	
medical	23. PART t. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest, above, or heart feiture. List only one cause many and the cardiac or reapiratory arrest.													
	interval Between													
2	IMMEDIATE CAUSE (Final disease or condition resulting in death)													
event,	disease or condition resulting in death) a. Corway artry disease with 24/1000y Due to (or as a consequence or): unde ceramay worffyreway													
CERTIFICATION	Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):													
S	cause. Enter UNDERLYING													
TIFIC	CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF):													
P F	reaulting in death) LAST													
	PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS													
	PARI II. Other algrimcant	condition	a contributing to	n the unde	Part I. 24a. WAS AN AUTOPSY PERFORMED?			24b.	WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO					
DIC.	P						1	YES 2	NO		COMPLETION OF CAUSE OF DEATH?			
Shows													1 YES 2 NO	
AN.	DID TOBACCO US	E CONTR	RIBUTE TO CA	USE OF DE	EATH YE	S KUNG	1U 🗆 0	ICERTAII	N 🔲 I					
SICIA	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one)													
YSI	1 TYES 2 NO		HOSPITAL:	ER/Outpatient	3 🗆 DOA	OTHER:	Home 5 0	Residence	6 Other (Sp	pec/fv)				
	27. MANNER OF DEATH		28e. DATE OF		28b. TIMI	E OF 28	. INJURY AT		28d. DESCR	-	NJURY OCC	URED		
ZE IS Marked, TED BY PH	Heturel 5 Pe	ending restigation	(Month, D	sy, rear;	INJ		WORK?	2 NO						
E 60	2 0 0 1111	ould not be	28e. PLACE O	F INJURY - At	home, ferm, a	treet, fectory	office		28f. LOCATIO	ON (Street e	nd Number	or Rural R	loute Number,	
			bunding,	etc. (Specify)					City or To	own, Stete)				
	4 Promicide determined													
	29e. CERTIFIER (Check only one) CERTIFYINO PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(e) and manner as stated.													
M M	(Check only													
COMPLETED	(Check only one) 2 MEDICA	AL EXAMINE	R: On the basis of e		or investigation	n, in my opin	on, death oc	cured at the	fime, date and	place, en	d due to the	cause(e)) end manner ee stated.	
BE COMPLE	(Check only	AL EXAMINE	R: On the basis of e		or investigation	n, in my opin		CENSE NUI		l place, en) end manner ee stated. (Month, Day, Year)	
E H	(Check only 2 MEDICA 29b. SIGNATURE AND TITLE O	F CENTIFIER	R: On the basis of e	ramination end/						l place, en				
TO BE COMP	(Check only one) 2 MEDICA	F CENTIFIER	R: On the basis of e	ramination end/		Print)	29c.	CENSE NUI	10ER 2		29d. DATE			
E H	(Check only 2 MEDICA 29b. SIGNATURE AND TITLE O	F CENTIFIER	R: On the basis of a	ramination end/	TEM 27) (Type,	Print)	29c.	CENSE NUI			29d. DATE			



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

	Pag.	
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician,	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page be fled within 72 hours after death with the State Deat, of Heath and Mental Honeine prior to burial, cremation or removal	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 33671 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last)

	THELMA	ONEIT	A HEINE						MON	25-95	DAY	YEAR	4:30 A	M
	4. SOCIAL SECURITY NUMB	BER	5. SEX	6. AGE (In yrs. les	st birthday)		R 1 YEAR	IF UNDER 24 HRS.	7. DATI	E OF BIRTH		6. BIRTH	PLACE (State or Foreign	_
	217-58-93	59	1 🗌 M 2 💢 F	86	YRS.	MONTHS	DAYS	HOURS MIN.		oth, Day, Year)	1908	Mar		
	9e. FACILITY NAME (If not in	stitution, give s	street end number)			9b. CIT	Y, TOWN C	OR LOCATION OF I	DEATH	201		ITY OF D		
DIRECTOR	Harford I		al Hospi	tal			Havr	e de Gra	ace		Hai	for	1	
3EC	10e. STATE	10b. COUNT	Υ		10c. CITY	r, TOWN	OR LOCAT	TION					10d. INSIDE CITY	_
	Maryland	F	Harford			Ec	lgewo	ood					LIMITS?	
FUNERAL	100. STREET AND NUMBER		- 11				101	I. ZIP CODE			10g. CITI	ZEN OF W	HAT COUNTRY?	
	1304 E. Cl	over \						2104	0			USA		
B	11. MARITAL STATUS 1 Never Merried 2 3 Widowed 4 Divo		12. WAS DECEDEN FORCES? 1 IF YES, GIVE W	YES 2 X	NO		If yes, sp	ecity Cuben, Maxic 2 NO Spec	an, Puerto		e or No —	14. RACE Bleck Speck	- American Indian, White, etc.	
		EDENT'S EDU highest grade		16a, DE	CEDENT'S	USUAL O	CCUPATIO	ON	16	b. KIND OF BU	SINESS/IND	USTRY		_
<u> </u>	Elementary/Secondary (0		College (1-4 or 5	1//0	. Do NOT us	ork done e retired.)	during mo	ist of working						
COMPL	12				Homer	make	r			Hor	ne			
5	17. FATHER'S NAME (First, Mi							18. MOTHER'S N	AME (First,	Middle, Malden	Surname)			
B E		Lant	Z					Ada	Loui		anson			
5	19a. INFORMANT'S NAME (7)			19				and Number or Rural			m, State, Zip	Code)		
	Donald L. He				Rd.	1, B	ox 5	2, Penho	ook,	Va. 2	24137			Ш
	20e. METHOD OF DISPOSITI	n 3 🗆 Rem	oval from State	20b. PLACE / cametery, cre	AND DATE O	F DISPOS	SITION (Na	ama of	DA	TE 20c. LC	CATION -	Ofty or To	vn, State	
-	4 Donation 6 Other 21. SIGNATURE OF UNERA		COURCE	Trinit	y Lu	ther	an C	emetery	10-2	28-195	Joppa	a, Mo	d	
- 1	14.1	/	MA	/				D ADDRESS OF F		TTT F	diner:	1 11	me, P.A.	
- 1	MIONIVI	A												
_	MAHIE	W 1	x / yell	M		1 1	317	Cokeshu	ry Ro	Abi	nador) M	1. 21009	
	23. PART I. Enter the di	sesses, or o	complications the	t caused the de	ath. Do n	1 1	317	Cokeshu	ry Ro	Abi	nador) M	21009 Approximate	
	23. PART I. Enter the di shock, or he IMMEDIATE CAUSE (Fin disease or condition resulting in death)	estt jellure.	complications the	t caused the de lee on each line	eath. Do no	1 1	317	Cokeshu	ry Ro	Abi	nador) M	1. 21009	
	IMMEDIATE CAUSE (Fin	estt jellure.	complications the List only one cau	t caused the de	ath. Do no	1 1	317	Cokeshu	ry Ro	Abi	nador) M	Approximats interval Between	
NO	IMMEDIATE CAUSE (Find disease or condition resulting in death)	eei	a. Dut to	t caused the delete on each line	MANUENCE OF	1 1	317	Cokeshu	ry Ro	Abi	nador) M	Approximats interval Between	
ALION	IMMEDIATE CAUSE (Fin disease or condition resulting in death) Sequentially list conditi if any, leading to immed	ions, dilate	a. Out TO	t caused the delete on each line (OR AS A CONSECUTION AS A CONSECUTION AS A CONSECUTION AS A CONSECUTION AS A CONSECUTION AS A CONSECUTION AS A CONSECUTION AS A CONSECUTION AS A CONSECUTION AS A CONSECUTION AS A CONSEC	DUENCE OF	1 1	317	Cokeshu	ry Ro	Abi	nador) M	Approximats interval Between	
FICATION	IMMEDIATE CAUSE (Find disease or condition resulting in death) Sequentially list condition if any, leading to immediate cause. Enter UNDERLY! CAUSE (Disease or injured)	ions, dilate	a. Due to	COM AS A CONSECUTION AS	CUENCE OF	1 1	317	Cokeshu	ry Ro	Abi	nador) M	Approximats interval Between	
HILLAHON	IMMEDIATE CAUSE (Findisease or condition resulting in death) Sequentially list condition if any, leading to immediate. Enter UNDERLY!	ions, diate	a. Due to	COM AS A CONSE	DUENCE OF	1 1	317	Cokeshu	ry Ro	Abi	nador) M	Approximats interval Between	
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AL CENTIFICATION	IMMEDIATE CAUSE (Fin disease or condition resulting in death) Sequentially list conditi if any, leading to immedicause. Enter UNDERLY! CAUSE (Disease or injuichst initiated events	dons, diste	a. Due to	COM BE CONSE	DUENCE OF	ot enter	317 the mo	Cokesburge aud Ahlly DEMM	CY ROOM SE CONTINUE OF THE PROPERTY OF THE PRO	Abi	nador Iratory sm	n, Mc	Approximats interval Between	ith
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CDICAL OF	IMMEDIATE CAUSE (Fin disease or condition resulting in death) Sequentially list condition if any, leading to immediates. Enter UNDERLY! CAUSE (Disease or injuit that initiated events resulting in death) LAST	ions, diate NG ry	a. b. C. C. Dust To	COM AS A CONSE	DUENCE OF	ot enter	317 the mo	Cokesburde of dying, audie of	Part I.	24e. WAS AN	nador Iratory sm	n, Mc	Approximats Interval Betwee Onset and Dael WERE AUTOPSY FINDING AMALABLE PRIOR TOS	ith
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ED BI FRISICIAN. MEDICAL CE	Sequentially list condition resulting in death) Sequentially list condition resulting in death) Sequentially list condition resulting in death) Sequentially list condition resulting to immed cause. Enter UNDERLYII CAUSE (Disease or injut that initiated events resulting in death) LAST PART II. Other significed DID TOBACCO US 25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 1	SE CONTI	a. b. Due to c. c. Due to c. d. Due to CA RIBUTE TO CA POSPITAL: 1 Unpatient 2 28e. DATE OF (Month, D. 28e. PLACE OF building, CIAN: To the best of an	(OR AS A CONSECUTION OF THE CONS	DUENCE OF SUPERIOR OF DOAD	ot enter	The moderiying only one) RE: sing Home 28c. INJU WO'I ory, office	Cokesbude of dying, audience of discovery at a company at a	Pert I. Pert I. 28d. DE 28f. LOC	24a. WAS AN PERFOIL TO YES T	AUTOPSY MED? NJURY OCCURRED Number	24b. 24b. urrel Record, cause(s)	WERE AUTOPSY FINDING: AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	ith

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral directic, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be netified at once. BALTIMORE, MARYLAND 21215-0020

1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CEF	RTIFIC	CATE O	DEATH		REG. NO).			
	1. DECEDENT'S NAME (First, Middle, Last)							OF DEATH			3. TIME OF DEATH	
	Charles E	llsworth	Humes				Oct.		25 199	YEAR	F.00 7	75 - 64
	4. SOCIAL SECURITY NUMBER		AGE (In yrs. lest bi	rthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE O		23 19		5:00 Z	
	213-07-9537	1 2 M 2 F			ONTHS DAYS	HOURS MIN.	(Month,	Day, Year)		Country	y)	7
			86					17,	1909	Penr	nsylvania	
	9a. FACILITY NAME (If not institution, give :			1	b. CITY, TOWN	DR LOCATION OF D	EATH			YTY OF D		
6	4030 Old Rocks	Rd.			Str	eet				Han	cford	
5	RESIDENCE OF DECEDENT									1100	LOIG	
DIRECTOR	10a. STATE 10b. COUNT		1	Oc. CITY,	TOWN DR LOC	ATION					10d. INSIDE CITY	
ā	Maryland H	arford			Fall	ston				- 1	LIMITS?	
4	10e. STREET AND NUMBER				19	Of, ZIP CODE			I ton CITI	ZEN OF W	HAT COUNTRY?	
2	2520 Pleasantvil	le Rd.				2104	7		log. Citi			
FUNERAL	11. MARITAL STATUS									USA	4	
5	1 Never Married 2 Married	12. WAS DECEDENT &	YES 2 NO	D	13. WAS DI	CENDENT OF HISPA	NIC ORIGIN?	(Specify Ye	a or No-	14. RACE	- American Indian, White, atc.	
BY	3 Widowed 4 Divorced	IF YES, GIVE WAR				S 2 X ND Speci		rount, arou		Specif	ha:	
											"White	
E I	15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	16a. DECEI	DENT'S US	SUAL OCCUPAT	IDN	16b.	KIND OF BU	ISINESS/IND	USTRY		
Щ	Elementary/Secondary (0-12)	College (1-4 or 5+)			rk done during r retired.)							
필	12		Ov	mer/	Operat	or		Gr	ocery	Sto	re	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)					18. MOTHER'S NA	ME (First M					
0	Charles H. Hu	nes					nown	date, meloen	ournaire)			
BE	19a. INFORMANT'S NAME (Type/Print)		F-100									
2	Ruth S. Humes		19b. M	IAILING A	DDRESS (Street	and Number or Rural	Route Numbe	or, City or Tox	vn, State, Zip	Code)		
-	radi 5, nulles		252	(O P)	easant	ville Rd	., Fa	llsto	n, Md	. 21	047	
	20a. METHOD OF DISPOSITION 1 M Buriel 2 Cremellon 3 Rem	comi from State	20b. PLACE AND	DATE OF	DISPOSITION (OATE		CATION -			
	4 Donation 5 Other (Specify)		Mt. Oli	vet.	Cemete	ry 10	-27-9	5 Ha	nover	Da		
- 1	21. SIGNATURE OF AUHERAL SERVICE LIC	CENSEE	1		22. NAME	AND ADDRESS OF FA	CILITY					
- 1	► 1/1/2)	1/4	/.		Howa	ird K. Mc	Comas	III	Funer	al H	ome, P.A.	
_	signey /	1 Mus	13		1317	Cokesbu	ry Rd	. , Ab	ingdo	n, M	d. 21009	
	23. PART I. Enter the diseases, or a shock, or heart failure.	complications that c	aused the death	. Do not	anter the m	oda of dying, aud	h aa cardi	ac or resp	iretory arr	eat,	Approximate	
- 7	IMMEDIATE CAUSE (Final	cist only one cause	on each line.								Interval Betwee	
	disease or condition	A	LZHE,	MED	8						Onset and De	. WEIT
Н	resulting in death)	B. DUE TO (OI	R AS A CONSEDUE	NOS OTH	-						yrs	
					Pa /							
CERTIFICATION	Sequentially list conditions,	b	Hyperte RAS A CONSEDUE	1-30							10	
Ĕ	if any, leading to immediate	DUE TO (OI	R AS A CONSEDUE	NCE DF):								
3	CAUSE (Disease or injury	с										
는 I	that initiated eventa	DUE TO (DI	R AS A CONSEDUE	NCE DF):								
15	resulting in death) LAST	d										
	DART II On a stantile of a stantile											
EDICAL	PART II. Other aignificent condition	s contributing to de	eth but not reau	ilting in	the underlyle	ng ceuse given in	Part I.	24s. WAS AN PERFOR		24b.	WERE AUTOPSY FINDING AMAILABLE PRIOR TO	GS
8 1							_	1 YES 2			COMPLETION OF CAUSE	E
WE									9	- 1	OF DEATH?	
	DID TOBACCO USE CONT	RIBUTE TO CALL	SE OF DEATH	YES	D NO F	UNCERTAI					10 125 20 110	
4	25. WAS CASE REFERRED TO MEDICAL				(Check only one						NII	
PHYSICIAN:	EXAMINER?	HOSPITAL:		To	THER:	~/						vel (tra)
₹S		1 Inpetient 2 E			-	me 5 Hesidence	8 🗆 Other	(Specify)				000
표	27. MANNER OF DEATH	28e. DATE OF IN. (Month, Day,		Bb. TIME (JURY AT ORK?	28d. DESC	RIBE HOW I	NJURY OCC	UREO		
B	1 Natural 5 Pending Investigation				M 1 🗆	YES 2 ND						3
a	3 Suicide 8 Could not be	28e. PLACE OF II	NJURY — At home,	ferm, etre	et, factory, offi	ce	28f. LOCA	TIDN (Street	and Number	or Rural Ro	oute Number.	\neg
巴山	4 Homicide determined	building, atc	. (Specny)				City or	Town, State)				- 1
COMPLETE	29a. CERTIFIER				_							_
린	(Check only	CIAN: To the best of my										
5	2 MEDICAL EXAMINE	R: On the beels of exam	ination and/or inve	atigation,	in my opinion,	death occured at the	lime, dete a	nd place, an	d due to the	cause(a)	and manner as stated.	
	29b. SIGNATURE AND TITLE OF CERTIFIER	1 1				29c. LICENSE NUI	MBER		29d DATE	SIGNED	(Month, Day, Year)	\dashv
H	1110	/_				7 2	488	9	D. DATE	1.45	2 / S S	
2	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CALLES	OF OFATH ATTENDED	0.73		100	100	/		10.	03 13	
		OMPLETED CAUSE	17 RAD	LIVPO, Pr	10 PD	D3 Rel A	1.00	10	2-181	14	1-	
		19-7	121/20	- 1-46	1-100	, mi	116	610		(
	31. DATE FILED (Month, Day, Year)	32 REGISTRAR'S	SIDNATURE LEAD	11							ń	\neg
1	OCT 26 1995	film atten	such Marka	4								
	UU LAU IJJA											

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 5 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 show filled that the State Debt, of Health and Mental Hygiens prior to burial, cremation, or removal. To hours after death with the State Debt, of Health and Mental Hygiens prior to burial, crematical examiner must be notified at once.	
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	FOR STATE REGISTRAR		STATE UF I	ARYLAND) / DEPAF Certif	RTMENT O	F HEALTH	HAND	MENTAL	REG. NO.			
	1. DECEDENT'S NAME (First,	Middle, Last)	Lucy Reg						MONTH	ober 2		YEAR	3. TIME OF DEATH
- 1	4. SOCIAL SECURITY NUMB	ER	5. SEX	6. AGE (In yrs.	. last birthday)	IF UNDER 1 YE	EAR IF UND	ER 24 HRS.	7. DATE	OF BIRTH	25, 1	6. BIRTI	IPLACE (State or Foreign
	232-03-0119	D	1 🗌 M 2 💢 F	9	5 YRS.	MONTHS DA	AYS HOURS	MIN.		4, 19	ann	Count	t Virginia
	9e. FACILITY NAME (If not in	stitution, give st	treet and number)			9b. CITY, TO	WN OR LOCA	TION OF D		79 12		NTY OF D	
DIRECTOR	Manor Care-	Fernwo	od			Bethe	esda				Mont	gome	ery
Ä	10a. STATE	10b. COUNTY	1		10c. Cl	TY, TOWN OR L	OCATION						10d. INSIDE CITY LIMITS?
ā	Maryland	Mont	gomery		Ве	thesda							1 TYES 2XXNO
FUNERAL	10e. STREET AND NUMBER	4505	5 Chase	Avenue			101. ZIP CO	2081	4				what country? States
Ξ I	11. MARITAL STATUS		12. WAS DECEDEN	T EVER IN U.S.	ARMED	13. WAS	DECENDENT	OF HISPA	NIC ORIGIN	? (Specify Yes		14. RAC	E — American Indian.
	1 Never Married 2		FORCES? 1	YES 2	Хио		s, specify Cul			tican, etc.)		Spec	k, White, etc.
à ∥	3 X Widowed 4 Divo	rced					K	,,,,,,,			120		White
		EDENT'S EDUC		16a		USUAL OCCU		kina	16b.	KIND OF BU	SINESS/INC	DUSTRY	
<u>.</u>	Elementary/Secondary (0	1	College (1-4 or 5	+)	lila. Do NOT L	ise retired.)	ng most or wor	rung					
COMPLET	12			I	Homema	ker				Own Ho	me		
ő	17. FATNER'S NAME (First, M	iddle, Last)					18. MC	TNER'S N	AME (First, I	Aiddle, Maiden	Surname)		
BE	Francis Bo	orgman					Ce	ecili	a Ko	rte			
	19a. INFORMANT'S NAME (7					G ADDRESS (S							
임	James W. H	ınt			4505	Chase	Avenue	e, Be	thes	da, Ma	ryla	nd	20814
	20a. METHOD OF DISPOSIT			20b. PLA	CE AND DATE	OF DISPOSITIO	N (Name o O	ct. 3	O, DAT	E 20c. LO	CATION -	City or To	own, State
	1 X Buriel 2 ☐ Crematic 4 ☐ Donation 5 ☐ Other		ovel from State	St.	Josep	h's Ce	metery	199	5	Howe	svil	le,	W. Virginia
	23. PART I. Sitter the dishock, or h	12	XX	1-5	M0084	6 Chey Beth	ert A. yy Cha nesda, e mode of c	se, Mar	lnc. yland	1336	14 - 35	01	Bethesda- In Avenue
	iMMEDIATE CAUSE (Fir disease or condition resulting in death)	nei	Myocar	dial I	nfarct	ion							Onset and Death
				(OR AS A CO									C 36 - 41 -
NO.	Sequentially list condit		b. Corona	OR AS A CO									6 Months
AT	If any, leading to imme cause. Enter UNDERLY	ING											
CERTIFICATION	CAUSE (Disease or injuthat initiated eventa resulting in death) LAS		DUE TO	(OR AS A CO	NSEQUENCE (OF):							
ö	DART II Osh I Idlan			4	- a lal	1 4 1			D 41				
NA I	Dementia					in the unde	riying cous	e given ir	Part I.	PERFO	RMED?	24	b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
ă													1 TYES 2 NO
MEDIC	DID TOBACCO U	SE CONT	RIBUTE TO CA	USE OF D	EATH Y	ES NO	UN 🔲 C	ICERTA	NM				
N: MEDIC	25. WAS CASE REFERRED 1	O MEDICAL		28. F	PLACE OF DE	ATN (Check onl)	r one)						
SIAN: MEDIC			HOSPITAL:	ER/Outpetier	N 3 DOA	OTHER:	Nome 5 🗆	Residence	6 🗆 Othe	r (Specify)			
SICIAN: MEDIC	EXAMINER? 1 ☐ YES 2 🙀 NO		1 Inpatient 2		-	VI 00 1	c. INJURY AT		28d. DE	CRIBE NOW	IN HIRY OC	CHRED	
HYSICIAN: MEDIC	1 YES 2 NO 27. MANNER OF DEATN		28a. DATE O		28b. TI		WORK?				1100111 00	0001120	
	1 YES 2 NO 27. MANNER OF DEATN 1 Netural 5	Pending Investigation	28a. DATE O	INJURY Day, Year)		LURY	WORK?	□ NO			MOONT OC	JOUNED	
B√	1 YES 2 NO 27. MANNER OF DEATN 1 Netural 5 2 Accident	Pending Investigation	28a. DATE OI (Month, I	Oay, Year) OF INJURY /	IP.	LURY	WORK?	NO NO	28f. LOC	ATION (Street	and Numbe		Route Number,
ED BY	1 YES 2 NO 27. MANNER OF DEATN 1 Netural 5 2 Accident	Pending	28a. DATE OI (Month, I	Pay, Year)	IP.	M M	WORK?	NO NO	28f. LOC C/ty	ATION (Street or Town, State	and Numbe		Route Number.
ED BY	1 YES 2 NO 27. MANNER OF DEATN 1 Netural 5 O 2 Accident 3 Suicide 8 O 4 Nomicide 29a. CERTIFIER (Check only 1 S CERT	Pending Investigation Could not be determined	28a. DATE OI (Month, I	Day, Year) DF INJURY — A , atc. (Specify)	At home, farm	M street, factory	WORK?		Crty	or Town, State	and Numbe	er or Rural	Route Number.
ED BY	1 YES 2 NO 27. MANNER OF DEATN 1 Noturel 5 2 Accident 3 Suicide 8 4 Nomicide 29a. CERTIFIER (Check only)	Pending Investigation Could not be determined	28s. DATE Of (Month,) 28s. PLACE obuilding	Ony, Year) OF INJURY I atc. (Specify) I my knowledge	At home, farm	street, factory	WORK? 1 YES 2 7, office	ace, and du	City	or Town, State	and Numbe	or or Rural	Route Number,
COMPLETED BY	1 YES 2 NO 27. MANNER OF DEATN 1 Noturel 5 2 Accident 3 Suicide 8 4 Nomicide 29a. CERTIFIER (Check only)	Pending Investigation Could not be determined	28s. DATE Of (Month, I 28s. PLACE building ICIAN: To the best of ER: On the basis of	Ony, Year) OF INJURY I atc. (Specify) I my knowledge	At home, farm	street, factory	WORK? 1 YES 2 , office o, date and plation, death oc	ace, and du	City a to the care e time, data	or Town, State	and Numbe	er or Rural sted.	
BE COMPLETED BY PHYSICIAN: MEDICA	1 YES 2 NO 27. MANNER OF DEATN 1 Notural 5 2 Accident 3 Suicide 8 4 Nomicide 29a. CERTIFIER (Check only one) 2 MEZ	Pending Investigation Could not be determined	28s. DATE Of (Month, I 28s. PLACE building ICIAN: To the best of ER: On the basis of	Ony, Year) OF INJURY I atc. (Specify) I my knowledge	At home, farm	street, factory	work? Tes 2 office office office office 29c. L	ice, and du	City a to the care e time, data	or Town, State	and Numbe	er or Rural eted, the cause	(a) and manner as stated. D (Month, Day, Year)
E COMPLETED BY	1 YES 2 NO 27. MANNER OF DEATN 1 Notural 5 2 Accident 3 Suicide 8 4 Nomicide 29a. CERTIFIER (Check only one) 2 MEZ	Pending Investigation Could not be determined TIFYINO PHYS CAL EXAMINE	28s. DATE Of (Month, I 28s. PLACE building ICIAN: To the best of ER: On the basis of I	DF INJURY — A stc. (Specify) If my knowledge axamination and	At home, ferm	JURY M street, factory	work? Tes 2 office office office office 29c. L	ice, and du cured at th	City a to the care e time, data	or Town, State	and Numbe	er or Rural eted, the cause	(a) and manner as stated.
BE COMPLETED BY	1 YES 2 NO 27. MANNER OF DEATN 1 Netural 5 2	Pending Investigation Could not be determined TIFYINO PHYS CAL EXAMINE	28a. DATE OI (Month, I 28a. PLACE of building ICIAN: To the best of ICIAN: To the ICIAN: T	DF INJURY — A stc. (Specify) I my knowledge examination and	thome, farm e, death occur d/or Investigat	JURY M street, factory	WORK? 1 YES 2 , office o, data and pla silon, dasth oc 29c. L D2	ice, and du cured at th ICENSE NI 6571	a to the care time, data	or Town, State	and Numbe	or or Rural ated, the cause TE SIGNE	(a) and manner as stated. D (Month, Day, Year)

DNMN-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760

								9	5	33674
	1 - FOR STATE REGISTRAR	STATE OF MARYLA		RTMENT OF			MENTAL HYGIEI			
	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF DEATH			3. TIME OF DEATH
	F	Roger Christ	topher	Huber			October 2	4. 19	995	10:30 P M
	The Control of the Co		yrs. lest birthday)	IF UNDER 1 YEA		F UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)		0. BIRTH	PLACE (State or Foreign
		1X M 2 □ F 30	YAS.	MONTHS DAY	rs H	OURS MIN.	July 23,	1965	Mar	yland
	9e. FACILITY NAME (If not institution, give street			9b. CITY, TOV	VN OR I	LOCATION OF DI			INTY OF D	
DIRECTOR	2800 Cheverly Aven	ue		Cheve	rly			Pri	nce	George's
EC	100. STATE 10b. COUNTY		10c. CIT	Y, TOWN OR LO	CATION	1				10d. INSIDE CITY
1 8	Maryland Prince	George's	Che	verly						LIMITS?
A.	10e. STREET AND NUMBER				10f. 21	P CODE		10a, CIT	IZEN OF W	THAT COUNTRY?
FUNERAL	2800 Cheverly Aven	ue		İ	20	785				States
S	11. MARITAL STATUS 1	2. WAS DECEDENT EVER IN L	J.S. ARMED	13. WAS			NIC ORIGIN? (Specify Ye			- American Indian,
	1 X Never Married 2 Merried	FORCES? 1 YES	2 X NO		yes 2		in, Puerto Rican, atc.)		Black Speci	
ВУ	3 Widowed 4 Divorced					A(spoon,	,.			White
道	15. DECEDENT'S EDUCAT (Specify only highest grade co	fION 1 mpleted)	6a. DECEDENT'S	work done during	ATION most o	l working	16b. KIND OF BU	SINESS/IN	DUSTRY	
삗		College (1-4 or 5+)	life. Do NOT us	,						
COMPLETED	12 17. FATHER'S NAME (First, Middle, Last)		ong Dis	tance			Bell A		ic	
	Robert C. Huber						ME (First, Middle, Melder	,		
BE	19e. INFORMANT'S NAME (Type/Print)		105 200 100	4D40500 (0)			Joyce Heve Route Number, City or Tox			
임	Robert & Ellen Hube	r		as 10		Number of Hurai i	Houte Number, City or Tol	vn, State, Zij	p Code)	
	20a. METHOD OF DISPOSITION	20h P	LACE AND DATE	-		of.	OATE 20c. L	OCATION —	Ola T-	0.00
	1 Buriel 2 Cremation 3 Remova	I from State comet	ery, crematory or o esapeak	ther place)	2+0	ייי	1			Maryland
	21. SIGNATURE OF FUNERAL SERVICE LICEN	ISEE	csapeak	22. NAMI	E AND /	ADDRESS OF FA	CILITY			Marytanu
	I Cilled &	Ran					Services,			
\vdash	22 DADT I Enter the diseases or any	· Jugap		[933	Gis	t Avenu	e, Silver	Spri	ng, i	MD 20910
	23. PART I. Enter the diseeses, or con ahock, or heart failure. Lis	it only one ceuse on esc	h line.	not enter the	mode	or dying, suc	h aa cardiec or reas	piratory ar	reat,	Approximate interval Between
	iMMEDIATE CAUSE (Final disease or condition	0		. \ - 1	^		, 1			Onset and Death
	resulting in death)	OVO STOCK OF AS A C	C M	11/11/	100	al lec	toencept	10/0/	Zeth	y 6 mar
_		Openio (on as a c	ONSEGUENCE O	r):			U	U	(/
RTIFICATION	Sequentially list conditions, if any, isading to immediate	OUE TO (OR AS A C	ONSEQUENCE OF	F):						
\ <u>\ \</u>	csuse. Enter UNDERLYING									İ
画	CAUSE (Disesse or injury that initiated events	DUE TO (OR AS A C	ONSEQUENCE OF	F):						
	resulting in death) LAST									
ᅙ	PART II. Other significent conditions of	contributing to death but	not consisting	la the contest			2			
MEDICAL	<u> </u>	to dectir but	not resulting	in the under	ying c	euse given in		RMED?	24b.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO
						-	1 [] YES	S X NO		COMPLETION OF CAUSE OF DEATH?
	DID TOBACCO USE CONTRIE	PLITE TO CALISE OF	DEATH VE	.c. 🗖 .uo		111 16557411				1 YES 2 NO
AN	25. WAS CASE REFERRED TO MEDICAL		PLACE OF DEAT			UNCERTAI	и Ц			
SICIAN:	EXAMINER?	IOSPITAL:		OTHER:						
РНУ	27. MANNER OF DEATH	25e. DATE OF INJURY	26b. TIM		INJURY		5 Other (Specify) 28d. DESCRIBE HOW	IN HIRV OC	CHRED	
	1XXNetural 5 Pending	(Month, Day, Year)	INJ	URY	WORK?	2 NO	ZOG. DESCRIBE NOW	INJUNT OC	CONED	
D BY	2 Accident Investigation 3 Suicide & Could get be	260. PLACE OF INJURY -	At home, ferm, a				261. LOCATION (Street	and Number	or Rumi A	oute Number
ш	4 Nomicide 6 Could not be determined	building, atc. (Specify,)				City or Town, Stete)		
COMPLET	29e. CERTIFIER 1 CERTIFYING PHYSICIA	N: To the best of my knowled	lge, death accurre	ed at the time	late er	t place, and don	to the course of and			
MK.		On the baels of examination e								and menner se stated
	299 SIGNATURE AND TITLE OF CERTIFIER			, -,						
B	(6//				29	LICENSE NUN				(Month, Day, Year)
	V V V					1610)	I UC	copei	25, 1995

3800 Reservoir Road, NW,

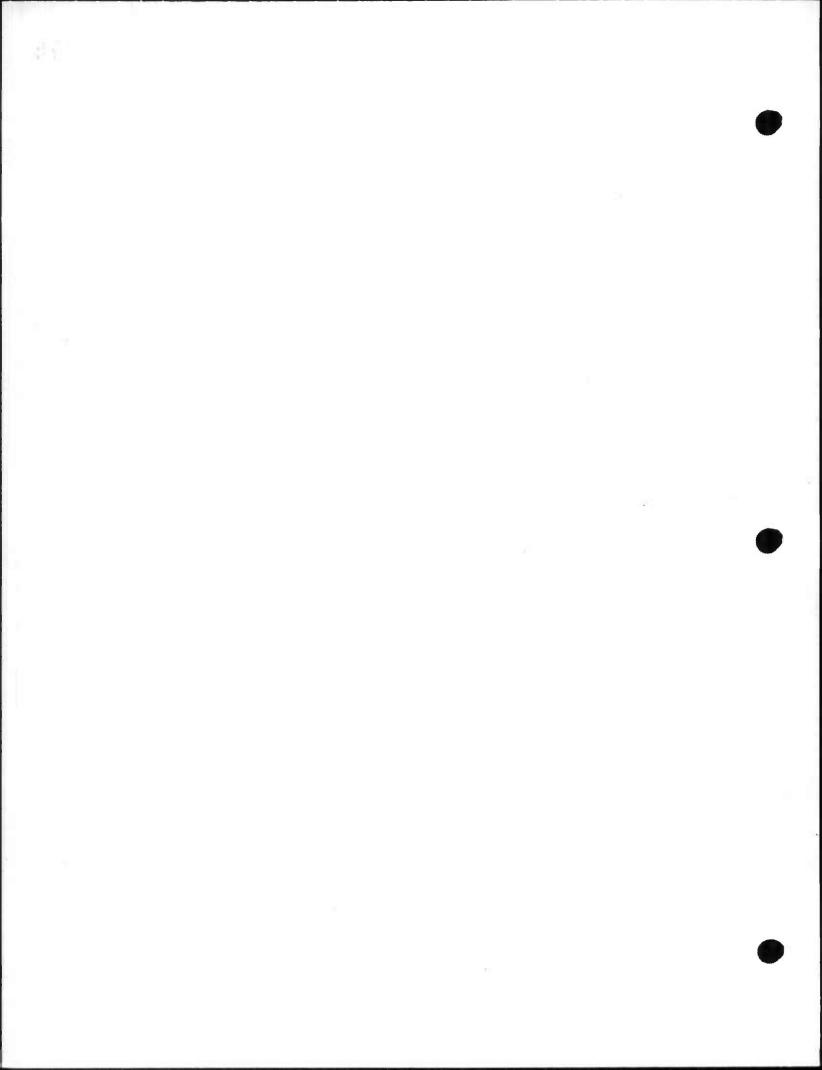
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print)

Andrew R. Pachner, M. D.,
31. DATE FILED (Month, Doy, Your)
OCT 2 7 1995
Julia Students

32. REGISTRAR'S SIGNATURE DHMH-16 Rev 1/89

Washington, DC

20007



TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

4. HERETON 4. HUNTER 45. HUNTER 4 PURAN. 10 1 - STATE / 23/95

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REG. NO.

F

	REGISTRAR		C	EKITF	CATE	JF UE	AIH		REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)	GENIEN	Œ		Hot	ff~	200	2. DATE OF MONTH	DEATH DA	"24	YEAR P	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER		AGE (In yrs. las	st birthday)	IF UNDER 1 YE	AR IF L	NDER 24 HRS.	7. DATE OF	BIRTH	01	a. SIRTH	PLACE (State or Foreign
	503-66-7774	1 🗆 M 2 🔀 F	75	YAS.	MONTHS DA	WS HOL	IRS MIN.	Jan.	ay, Year)		Sout	h Dakota
_	9a. FACILITY NAME (If not institution, give atn	eet and number)		-	9b. CITY, TO	WN OR LO	CATION OF D	EATH		9c. COU	NTY OF DE	EATH
DIRECTOR	Shady Grove Advent	ist Hospi	tal		Rockv	ille				Mo	ntgor	nery
E	10e. STATE 10b. COUNTY			10c. CITY,	TOWN OR L	OCATION						10d. INSIDE CITY
듬	South Dakota Grant	County		LaB	Bolt							LIMITS?
A	10e. STREET AND NUMBER					10f, ZIP	CODE			10g. CIT	IZEN OF W	HAT COUNTRY?
FUNERAL	P.O. Box 44					57	246			Uni	ted S	States
5	11. MARITAL STATUS	12. WAS DECEDENT EVER FORCES? 1						NIC ORIGIN? (or No-	14. RACE Black	- American Indian, White, etc.
BY	1 Never Married 2 Married 3 XX Widowed 4 Divorced	IF YES, GIVE WAR					NO Speci		, 0.0.,		Specif	White
ED	15. DECEDENT'S EDUC. (Specify only highest grade of		18a, DE	ECEDENT'S U	JSUAL OCCU	PATION	undring	16b, KI	ND OF BUS	SINESS/INI	DUSTRY	WILLES
	Elementary/Secondary (0-12)	College (1-4 or 5 +)	life	Do NOT use	retired.)	y most or t	FORMING					
COMPLETED	9		Но	omemak	ker			(Own H	lome		4.7
	17. FATHER'S NAME (First, Middle, Last)							AME (First, Mich	dle, Maiden	Sumame)		
H	Joseph Finnegan 19a. INFORMANT'S NAME (Type/Print)						mma Ba					
۵	THE NAME OF THE PARTY OF THE PA							Route Number,				MD 20879
	Susan E. Madison 20a. METHOD OF DISPOSITION				FDISPOSITIO				20c. LO			
	1 № Burlel 2 □ Cremetion 3 № Ramo 4 □ Donation 5 □ Other (Specify)	val from Stata						3/95			-	uth Dakota
	21. SIGNATURE OF FUNERAL SERVICE LICE	ENSEE			-			ACILITY De			ral H	lome
	Michael D.	Fibbon	W					Park 1		2		
	23. PART i. Enter the diseases, or conshock, or heart fellure. L									iratory ar	real,	Approximate Interval Between
	IMMEDIATE CAUSE (Final	nat only one cadae	Dii aucii iiii	α,								Onset and Daath
	disease or condition resulting in death)	INTRAC	EREBA	RAL	HEN	NOR	RHAG	E				2 DAYS
		DUE TO (OR	AS A CONSE	OUENCE OF):							
S	Sequantially list conditions,	DUE TO (OR	AS A CONSE	OUENCE OF);							
¥	if any, leading to immediate cause. Enter UNDERLYING											
Ĕ	CAUSE (Disease or injury that initiated events	DUE TO (OR	AS A CONSE	QUENCE DF):							
CERTIFICATION	reaulting in death) LAST											
	PART II. Other aignificant conditions	contributing to date	ath but not	reaulting in	tha under	rlying cau	use given in	Part I. 2	Ia. WAS AN		24b.	WERE AUTOPSY FINDINGS
EDICAL									PERFOR			AVAILABLE PRIOR TO COMPLETION OF CAUSE
								`		10		OF DEATH?
Σ	DID TOBACCO USE CONTR	IBUTE TO CAUS	E OF DEA	ATH YES	S NC		INCERTA	N 🗆				
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		28. PLA	CE OF DEATI	H (Check only	one)						
S	1 TYES 2 NO	HOSPITAL:	l/Outpatient	3 DOA	OTHER: 4 Nursing	Home 5	Residence	8 Other (S	Specify)			
됩	27. MANNER OF DEATH	28a. DATE OF INJ (Month, Day, 1)		28b. TIME		c. INJURY .	AT	28d. DESCF	NOH JEIN	NJURY OC	CURED	
ВУ	1 Natural 5 Pending 2 Accident Investigation					_ YES	2 NO					
	3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF IN building, atc.	(Specify)	ome, farm, st	treet, factory,	offica			ON (Street i Town, State)		r or Rural R	loute Number,
COMPLETED												
립	and and	CIAN: To the best of my										
Š	one) 2 MEDICAL EXAMINES	t: On the basis of exam	ination and/or	investigation	ı, in my opini	on, death	occured at the	e time, date an	d place, an	d due to t	he cause(a) and menner as stated.
ш	29b. SIGNATURE AND TITLE OF CERTIFIER					290	LICENSE NU	MBER		29d. DA	TE SIGNED	(Month, Day, Year)
10 B	De MJ	>					D33	5941		•	10/25	55
۲	30. NAME AND ADDRESS OF PERSON WHO		OF DEATH (ITE								9	
	PURAN P M 31. DATE FILED (Month, Day, Year)	ATHUR =	F 401	50	WE	Des	1077NC	v DR	. 6	LOCK	MLE	MD20852
	OCT 27 1995	In Devoler	Rarball									

1. DECEDENT'S NAME (First, Middle, Last)

JAMES

FOR STATE REGISTRAR

BRIAN

31. DATE FILED (Mortin, Day, Year)

OCT 26 1995

3. TIME OF DEATH

0247

8. BIRTHPLACE (State or Foreign Country)

PRINCE GEORGES

Approximate Interval Between Onset and Death

24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?

after death. Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020 TO THE HOSPITAL OR ATTENDING PHYSICIAN; The law requires that the death certificate be maculal and DIVISION OF VITAL RECORDS, P.O. BOX 6876

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- 1	217-06-485	4	1 K M 2 [F	22	YRS.	MONTHS	DAYS	HOURS	MIN.	June	Day, Year)	1973	Country)	land
ı	Se. FACILITY NAME (If not	institution, give a	treef and number)			9b. CITY	r, TOWN	OR LOCATE	ON OF DE		,		TY OF DE	
TOR	PRINCE GI		HOSPIT	CAL C	ENTER	CH	IEVE	ERLY				PF	RINCE	E GEORGE
DIRECTOR	the STATE	186. COUNTY	*		10c. CI	TY, TOWN	OR LOCA	TION		_			T	Od. INSIDE CITY LIMITS?
	Maryland		ntgomery		R	ockv:		r. ZIP COD	E .			10a CITI		TAT COUNTRY?
ERA	14406 Peca		3						0853			log. Gill	USA	AI COUNTRY?
BY FUNERAL	11. MARITAL STATUS 1 (X Never Married 2 (12. WAS DECEDED FORCES? IF YES, GIVE	☐ YES	2 DENG		If yes, sp	CENDENT C	OF HISPAI	in, Puerto R	? (Specify Yelican, atc.)	s or No—	14. RACE -	- American Indian, White, atc.
8	18. DE	CEDENT'S EDU	CATION	16	a. DECEDENT					16b.	KIND OF BU	JSINESS/IND	USTRY	
IPLET	Elementary/Secondary	-	College (1-4 or 5	*)	(Give kind of iffe. Do NOT Stude	use retired.)	gunny m	ost or work!	ng		Colle	ge		
COMPL	17. FAYHER'S NAME (First,							16. MOT	HER'S NA	ME (First, M	liddle, Maider	n Surname)		
BE (Joshua S.				,						Robe			
2	Joshua S.											MD 20		
	208, METHOD OF DISPOSI	TION		20b. PL	ACEANDDATE				= , IN	DATE		OCATION -		n. Stete
	1 Ø-Burtet 2 □ Cremat 4 □ Donation 5 □ Othe	ion 3 L. Rem	ovsi from Statu	Gat	ry, cremetory of	leave	n Ce	emete	ry 1		95 S:	ilver	Spri	ng, MD
	21. SIGNATURE OF ELMEN	AL SERVICE CH	ENSEE	neli		_ 1	Fran		J. Co	ollin				Inc.
RTIFICATION	IMMEDIATE CAUSE (F disease or condition resulting in death) Sequentielly list cond if any, leading to imm cause. Enter UNDERL' CAUSE (Disease or in	Itions, ediate	DUE TO	OR AS A CO	ONSEQUENCE	OF):								Onset and Dea
CERTIF	that initiated events resulting in death) LA		d.	OR AS A CO	ONSEQUENCE	OF):								
MEDICAL	PART II. Other algoritic	cent condition	e contributing to	death but	not resulting	in the u	nderlyln	ng ceuse	given in	Part I.		N AUTOPSY ORMED? 2 NO		WERE AUTOPSY FINDING WAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? I YES 2 NO
AN:	DID TOBACCO		RIBUTE TO CA						CERTAI	N 🗆				
0	25. WAS CASE REFERRED EXAMINER? 1XX ES 2 NO	TO MEDICAL	HOSPITAL:		PLACE OF DE	OTHE	R:		asidenca	8 🗆 Other	(Specify)			
BY PHYS	27. MANNER OF DEATH 1 Netural 5 2 Accident	Pending Investigation	10/22	Day, Year) 2/95	2:1	A V W	1 🗆		√NO		cribe How	n stru		, automobile
ETED	3 Suicide 8 4 Homicide	Could not be determined	28a. PLACE (building	OF INJURY — , atc. (Specify)	stree t		ctory, offic	ca		City	or Town, State	end Number	or Rural Plo	erwyn
COMPLI	one)		ICIAN: To the best of											and menner as stated.
0	296. SIGNATURE AND TITE	LE OF CERTIFIE	R O A					29c. LIC	ENSE NU	MBER		29d. DAT	E SIGNED (Month, Day, Year)
O BE	30. NAME AND ADDRESS	n		te m				0.	C.M	. E		▶00	CT.	23,1995

32 REGISTRAR'S SIGNATURE

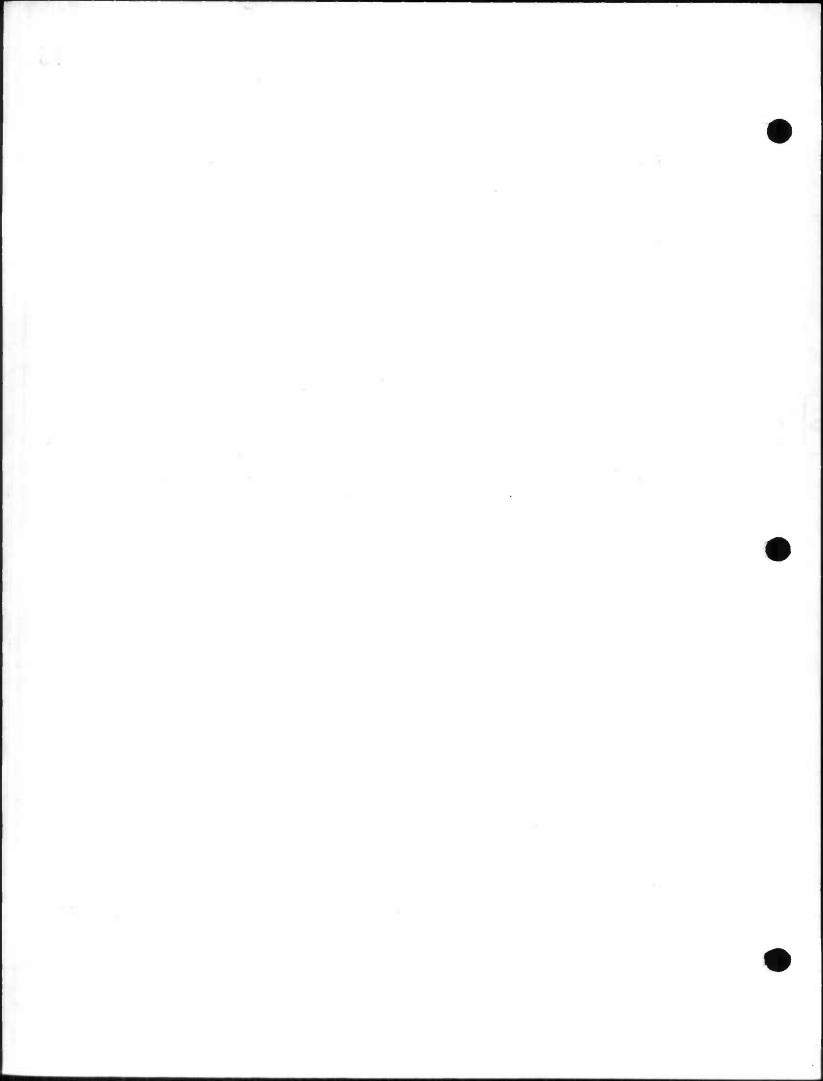
HULL

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

2. DATE OF DEATH OCT . 2

22°

1995



		1 - FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPAR	TMENT OF H	EALTH AND I	MENTAL HYGIEN		
		1. DECEDENT'S HAME (First, Middle, Last)	Α		11 1		2. DATE OF OEATH		3. TIME OF GEATH
		Norma	AVIS		Hand		October	9 199	5 826 A
_	1	4. SOCIAL SECURITY NUMBER		yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	8. B	IRTHPLACE (State or Foreign ountry)
2		577-48-4767	L	71 YRS.	MONTHS DAYS	HOURS MIN.	May 8, 19		Vermont
Should	 ~	9a. FACILITY NAME (If not institution, give s			9b. CITY, TOWN C	R LOCATION OF DE	ATH	9c. COUNTY C	OF DEATH
1. 2, 3	CTOR	Shady Grove Adve		a1	Rocl	<u>kville</u>		Mont	gomery
Pages	DIRE	10a. STATE 10b. COUNTY		10c, CIT	Y, TOWN OR LOCAT	ION			10d. IHSIDE CITY LIMITS?
permit. F			tgomery		Gaithers	burg			1 X YES 2 HO
	RAL	10e. STREET AND HUMBER			101	. ZIP CODE		10g. CITIZEH	OF WHAT COUHTRY?
020 physician. burial-transit	NER	118 Hutton Sti				20877			ed States
020 physician. burial-trar	FUN	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT EVER IN FORCES? 1 YES	2 XNO			IC ORIGIN? (Specify Yen, Puerto Rican, etc.)		RACE — American Indian, Black, White, atc.
	BY	3 Widowed 4 Divorced	IF YES, GIVE WAR OR DAT	TES	1 TYES	2 NO Specify			Specify: White
	8	15. OECEDENT'S EDU	CATIOH	16a. OECEDEHT'S	USUAL OCCUPATION	ON .	16h KIHO OF BU	SIHESS/IHDUSTR	
F 8 3		(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind of a	work done during mo se retired.)	st of working	1000	01112007111000711	
ND 2 hospital	틸		2	Lib	rarian		Monte	omery (Co. Library
⋖ • • •	COMP	17. FATHER'S NAME (First, Middle, Last)				16. MOTHER'S NAI	ME (First, Middle, Maiden		oc. Biblary
# & & X	ш	Earle P	. Bevins				Ruth E.	Morga	ın
MAR retained 5 should	8	19a. INFORMANT'S HAME (Type/Print)		19b. MAJLIHG	ADORESS (Street a	nd Number or Rural F	Toute Number, City or Tow		
		Russell Hand,	Jr.	118 H	utton St	reet, Ga	ithersburg	. Marvl	and 20877
ORE, 6 may be ctor. page		20a. METHOD OF DISPOSITION 1 □ Burial 2 ※ Cremation 3 □ Rem	20b. I	PLACE AHD DATE	OF DISPOSITIOH (Na	me of		CATION — City o	
MOR age 6 ma director.		4 Donation 5 Other (Specify)	Me	tropoli	tan Crem	atory	10/20 Ale	xandria	, Virginia
Ch. 100	-	21. SIGHATURE OF FUHERAL BUILDINGE LIC	ENGEE	10	22. HAME AN	D ADDRESS OF FAC	YTUE	Funera	
		Mide	(1) (dl	Here	10 F D	oom Dowl-			
hours after of in by the or removal.		23. PART i. Enter the diseases, or o	complications that caused	the death. Do r	not enter the mo	da of dving, such	Dr., Gall	retory arrest	g, MD. 20877
		snock, or naart fellure.	List Dnly one ceuse on each	ch ilne.					intarval Between
rz4 ho ly filled ation. o		iMMEDIATE CAUSE (Finel disease or condition	1/044	10. /	- File	. 11. de	-11		Onset and Deat
omplete omplete II, cremi		resulting in deeth)	OUE TO (OR AS A	CONSEQUENCE OF	FI:	11/hex co	*W		Schools
			OUE TO (OR AS A CO) DUE TO (OR AS A CO)	1.411 D	24210	0:50	es a		111-04-0
	RTIFICATION	Sequentisity list conditions, if any, leading to immediate	DUE TO (OR AS A	CONSEQUENCE OF	Pi:	11764	24		VGNFS
ate be prior trau	3	cause. Enter UNDERLYING CAUSE (Disease or injury	G						
ertifical ing phy giene pother	띹	that initiated events	DUE TO (OR AS A	CONSEQUENCE OF	F):				
T # BE P	111	resulting in desth) LAST	i						
0 2 2 3		PART II. Other significant condition	s contributing to death bu	t not resulting i	in the undariving	ceusa given in i	Part I. 24s. WAS AN	ALITOPRY	24b. WERE AUTOPSY FINDINGS
T # 5 5 -	CAL	Chronic 1	ob stancts	~ 0.1	W. a. a a.	116.00	PERFOR	RMEO?	AMILABLE PRIOR TO COMPLETION OF CAUSE
requires thaten signed of Health a	MEDIC		READED F	- 5/100	na o ro may	12/2 May	1 - YES 2	ZI-NO	OF DEATH?
requires been sign of Heal		DID TOBACCO USE CONTI		DEATH VE	S NO	LINICEDTAIN			1 YES 2 NO
has has Deg	NA I	25. WAS CASE REFERRED TO MEDICAL			H (Check only one)	UNCERTAIN	101		
F 8 8 5		EXAMINEN?	HOSPITAL:		OTHER:				
ATTENDING PHYSICIAN: ECTOR: After this certifica s after death with the Sts 28 is marked, or 8th	PHYSICIAN:	27. MAHNEB OF DEATH	26a. DATE OF IHJURY	28b. TIM		5 Reeldence	6 ☐ Other (Specify) 28d. DESCRIBE HOW I	N III DV OCCUPE	
NG PHYS auth with with		1 Heturel 5 Pending	(Month, Day, Year)		URY WO	RK?	200. DESCRIBE NOW I	NJOHT OCCURED	,
After death	BY	2 Accident Investigation 3 Suicide & Could not be	28s. PLACE OF INJURY -	- At home, term, a			281. LOCATION (Street	and Number or Bu	ral Bouta Number
28 is a star of the star of th	E	4 Homicide 6 Could not be	building, atc. (Specify	1)			City or Town, State)		The result reserves,
OR ATTEN DIRECTOR: hours after Item 28 to	COMPLETED	29a. CERTIFIER CERTIFYING PHYSI	CIAN: To the heat of my bossile	des deeth seems	4 -4 41 - 41 - 4 - 4				_
	M		CIAN: To the best of my knowled R: On the basis of examination						notes and manner or otal-d
THE HOSPITAL THE FUNERAL filed within 72 PORTANT: 11	1 1	29b. SIGNATURE AND TITLE OF CERTIFIER			.,, .,				
五 五 五 五 五 五 五 五 五 五 五 五 五 五 五 五 五 五 五	8	A LO MAN	0 1) me on		29c. LICENSE NUM	BER LL Q	29d. DATE SIGN	NED (Month, Day, Year)
2 2 3 X	유	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CALIFIE OF BEET	M'(ITEM 27) /3	Print)	4/17		Och	600020, 1993
,		Garylandans	IAD C			140 1	111	, 2	
6		31. DATE FILED (Month, Day, Year)	32 REGISTRAR'S SIGNAT		arove A	avents	1 musp. ta	1 100	Culle UD
-Y	1 1	OCT 9 A 100F	1.1 Marchan Rad	-11					

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4:20 AM

REG. NO.

by Medical Examiner - Dr. Taubed	BALTIMORE, MARYLAND 21215-0020	The same of the sa
cleaned by n	DIVISION OF VITAL RECORDS, P.O. BOX 68760	DITAL OD ATTENDING DUVERFORM The law requires that the that heath contribute has accounted within

FOR STATE REGISTRAR

		1. DECEDENT'S NAME (First, Middle, Last)	E		11 n	PA	1			2. DATE MONTE	OF DEATH		YEAR	3. TIME OF DEATH
		4. SOCIAL SECURITY NUMBER	5. SEX 6. A	GE (In yrs. le	st birthday)	# UNDER		IF UNDER	N 24 HRS.	7. DATE	OF BIRTH	7	B. BIRTHE	PLACE (State or Foreign
9		578-10 - 3350	1 📉 M 2 🗆 F	81	YRS.	MONTHS	DAYS	HOURS	MIN.	Augu	ist 16,	,1914	Vir	ginia
3 should	Œ	9a. FACILITY NAME (If not institution, give at		ا مط				OR LOCATI		ATH			TY OF DE	
~	СТОВ	Washington Adver	itist Hospi	.tai		так	SOMA	Par	K			Mont	gome	ry
permit. Pages 1,	DIRE	Maryland Princ	ce Georges		1	ry, rown o		TION						10d, INSIDE CITY LIMITS? 1 YES 2 XNO
·25	FUNERAL	100. STREET AND NUMBER 8603 Pinta Stre						I. ZIP COD	20735	5			_	HAT COUNTRY?
fing physician. the burial-transit	B	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Olivorced	12. WAS DECEDENT EVE FORCES? 1 Y IF YES, GIVE WAR O	ES 2/Q		1	yes, sp	CENDENT Coocity Cubs	ın, Mexicer	n, Puerto F	7 (Specify Yes Rican, etc.)	or No-	Black,	- American Indian, White, stc. White
hours after death. Page 6 may be retained by the hospital or attending physician. ed in by the funeral director, page 5 should be detached for use as the burial-tran or removal. medical examiner must be notified at once.	PLETED	15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12)		- (I	Sive kind of Do NOT u	s usual oc work done of se retired.)	luring m	ost of worldi			KIND OF BUS			eal estate
by the hospital of the detached for at once.	BE COMPL	17. FATHER'S NAME (First, Middle, Last) Thomas Tarleton	Hardy					16. MOT	HER'S NAM	ME (First, N	Middle, Meiden S Gills		04, 1	000000
ay be retained page 5 should be notified	TO B	192. INFORMANT'S NAME (Type/Print) Sandra I. Manahan		11	603	ADDRESS Pinta	Street	nd Number	or Runul A intor	Route Numb	oer, City or Town 0 20735	State, Zip	Code)	
ge 6 may lirector, pa r must b		20e, METHOD OF DISPOSITION 1 A Burlal 2 Cremation 3 Remo 4 Donation 5 Other (Specify)	1	206. PLACE cemetery, cr Cedar	AND DATE	The Cen	ete	ry O	ct. 2	26,19	20c. LOC 995 Suj	ation – c	d, M	rn, Stata D
after death. Page 6 m. by the funeral director, moval. Ical examiner must		24: SIGNATURE OF FUNERAL SERVICE LIC	of reco	ach				arro.		Ta				ome, Inc. .C. 20012
ours after of in by the or removal.		23. PART I. Enter the diseases, or c	omplications that cou	sad the d	ath. Do			ada ad ded	ing auch	an card	lec or respir		-4	Approximate
within 24 hours upletely filled in the cremation, or re- rent, the media		iMMEDIATE CAUSE Vinal disease or condition resulting in death)	List only and cause of	teve	te	t-w	for me	ici (U	re	,	nec or reapin	atory arre	ert,	Interval Between Onset and Death 2 days
th certificate be executed within-ea- ending physician and completely fill- litygiene prior to burial, cremation, or other traumatic event, the	ERTIFICATION	iMMEDIATE CAUSE Vinal disease or condition	DUE TO (OR A	AS A CONSE	ouence o	FI: Se	for ps	cel Cel	ve.	, and Card	or reaph	atory arre	at,	Interval Between Onset and Death
e death certificate be executed within-E4 he attending physician and completely fills Mental Hygiene prior to burial, cremation, jury, or other traumatic event, the	AL CERTIFICATION	immediate CAUSE Vinal disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initiated events	DUE TO (OR A	AS A CONSE	OUENCE O	P: Send River	f. ps	col	or.		24s. WAS AN A	WTOPSY		Interval Between Onset and Death
aires that the death certificate be executed within-tall signed by the attending physician and completely fill Health and Mental Hygiene prior to burial, cremation, ws any injury, or other traumatic event, the	MEDICAL CERTIFICATION	immediate Cause Vinal disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other aignificent conditions. Discusse Call boul	DUE TO (OR A DUE TO (OR A DUE TO (OR A DUE TO (OR A A C DUE TO (OR A A A A C DUE TO (OR A A A A C DUE TO (OR A A A A C DUE TO (OR A A A A C DUE TO (OR A A A A C DUE TO (OR A A A A C DUE TO (OR A A A A C DUE TO (OR A A A A C DUE TO (OR A A A A A C DUE TO (OR A A A A A C DUE TO (OR A A A A A C DUE TO (OR A A A A A A C DUE TO (OR A A A A A A A A A A A A A	AS A CONSE	OUENCE O	F): Se F): wd Ri F): in the unit	for ps	Col Col Scalar Scalar Scalar Scalar	given in F	Part I.		WTOPSY MED?	24b. V	Interval Between Onset and Deeth 2 days 3 weeks 5 weeks
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PHYSICIAN: The law requires that the death certificate be executed within this certificate has been signed by the attending physician and completely fill with the State Dept. of Health and Mental Hygiene prior to burial, cremation, riced, or item 23 shows any Injury, or other traumatic event, the	Y PHYSICIAN: MEDICAL	Sequentially list conditions, if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) PART II. Other aignificent conditions. DID TOBACCO USE CONTR. 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 27 NO 27. MANNER OF DEATH 1 Nintural 6 Pending	DUE TO (OR A DUE TO (OR A DUE TO (OR A DUE TO (OR A DUE TO (OR A A CONTRIBUTE TO CAUSE	AS A CONSE AS A CONSE AS A CONSE AS A CONSE AS A CONSE CONSE	OUENCE O OUENCE O OUENCE O OUENCE O TOUCH OUENCE O TOUCH OUENCE O TOUCH OUENCE O OUENCE O	F): F): In the unit South TH (Check of Other 4 Nurse	SW SW SW SW SW SW SW SW SW SW SW SW SW S	g cause (Col Col UNC	given in F	Part I.	24a. WAS AN A PERFORM 1 YES 2	WTOPSY MED?	24b. (Interval Between Onset and Death 2 days 3 weeks 5 weeks were autopsy findings and able Prior to completion of cause of death?
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AL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Est. AL DIRECTOR: After this certificate has been signed by the attending physician and completely fills. Thours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation. If item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the	OMPLETED BY PHYSICIAN: MEDICAL	immediate Cause Vinal disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other aignificent conditions DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 25 NO 27. MANNER OF DEATH 1 Netural 6 Pending Investigation 3 Suicide 6 Could not be determined 29a. CERTIFIER (Check only) CERTIFIER 1 CERTIFYINO PHYSIC	DUE TO (OR A DU	AS A CONSE AS A C	DUENCE O OUENCE	F): In the unit F): In the	ASSIMATION OF THE PROPERTY OF	g cause (Col Golden Solution Color Colo	given in F	Part I. 6 Other 28d, DESt City o	24a. WAS AN A PERFORA 1 YES 2) (Specify) CRIBE HOW IN. ATTON (Street an or Town, State)	JURY OCCU	JRED JRED 4.	Interval Between Onset and Death 2 days 3 weeks 5 weeks were autopsy findings await able Prior to completition of cause of Death? 1 YES 2 No
DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the DIRECTOR. After this certificate has been signed by the attending physician and completely fill hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, ifem 28 is marked, or Item 23 shows any Injury, or other traumatic event, the	MPLETED BY PHYSICIAN: MEDICAL	IMMEDIATE CAUSE Vinal disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other aignificent conditions are suiting in death) LAST DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 25 NO 27. MANNER OF DEATH 1 Natural 6 Pending Investigation of Could not be determined 29a. CERTIFIER (Check only 1 CERTIFYINO PHYSIC	DUE TO (OR A DU	as a conse S a conse S a conse S a conse C C C C C C C C C C C C C C C C C C C	OUENCE O OUENCE	F): In the unit F): In the	ASSIMATION OF THE PROPERTY OF	g cause g Col Grant	given in F	Part I. 6 Other 28d, DESc City o	24s. WAS AN A PERFORM 1 YES 2) (Specify) CRIBE HOW IN. ATION (Street an Fown, State) se(a) and mann and place, and	JURY OCCU	JRED A Rural Roll couse(a)	Interval Between Onset and Death 2 days 3 weeks 5 weeks were Autopsy Findings Amarable Prior to Completion of Cause of Death? 1 yes 2 no

Takowa

32. REGISTRAR'S SIGNATURE

Carroll Auc.

31. DATE FILED (Month, Day, Year)
001 24 1995

Park Wel.

20912

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

DRE, MARYLAND 21215-0020

(DS, P.O. BOX 68760), BALTIMORE, MARYLAND 21215-0020	TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	is certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	id, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be execu	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the 1 be fled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic

	FOR STATE REGISTRAR	STATE OF MAI	RYLAND /	DEPAR Ertifi	TMENT	OF H	IEALTH AND I	MENTA	L HYGIEN REG. NO.			
	DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH DAY OCTOBER 19, 1995 4:15								
	4. SOCIAL SECURITY NUMBER 136-03-7839	1 M 2 XXF	t birthday)	The second second second second						8. BIRTHPL	ACE (State or Foreign	
TOR	99. FACILITY NAME (If not institution, give street end number) Greenbelt Nursing Center				96. CITY, TOWN OR LOCATION OF D. Greenbelt					OF DEAT	eorge's	
DIRECTOR	nesidence of decedent 100. STATE 10b. COUNTY Maryland Monto	gomery			10c. CITY, TOWN OR LOCATION Silver Spring						d. INSIDE CITY LIMITS?	
FUNERAL	10e. STREET AND NUMBER 2317 Holly Spr		101. ZIP CODE 20905						States			
B	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Never Merried 4 Divorced	MED	If yee, specity Cuban, Mexican, Puerto Rican, etc.)					14. RACE — Bleck, V Specify:	American Indian, white, etc. White			
COMPLETED	15. DECEDENT'S EQUC (Specify only highest grade of Elementary/Secondary (0-12)	JSUAL OCCUPATION ork done during most of working retired.) 16b. KIND OF BUSINESS/INDUSTRY State of Maryland					đ					
BE CON	17. FATNER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Melden Surneme)								Fo			
5	19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) Wayne He Howells 19c. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) Same as #10											
	20e. METNOD OF DISPOSITION 1 M Juriel 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of complex), crematory or other place) Culpeper National Cemetery 10/23/95 Culpeper, Virginia										oinia	
	21. SIGNATURE OF FUNERAL SERVICE LICE		Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Md.20705									
												Approximate Interval Between Onset and Death
	disease or condition resulting in death) Due to (or AS A CONSEQUENCE OF): Sequentially list conditions Due to A CONSEQUENCE OF):										< 24 hours Syears	
CERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING										syears	
ERTIFI	CAUSE (Disease or injury that initiated events resulting in deeth) LAST d.											
- 1	PART II. Other algorificent conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY PERFORMED? AMILABLE PRIOR TO											AILABLE PRIOR TO
PHYSICIAN: MEDICAL	plone		1 ₀ Y			ES 2 X XIO		OMPLETION OF CAUSE DEATH?				
AN:	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN										2341	
SICI	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES ZY NO 1 Inpettent 2 ER/Outpettent 3 DOA Ther: Yes a Control one) OTHER: Yes a Control one) OTHER: Yes a Control one)											
ву Рну	27. MANNER OF DEATH 1XXNetural 5 Pending	26b. TIME	28b. TIME OF INJURY AT WORK? M 1 YES 25 YO NO			28d. DESCRIBE HOW INJURY OCCURED						
_	2 Accident investigation 3 Suicide 6 Could not be determined 28e. PLACE OF INJURY — At home, term, straet, factory, building, etc. (Specify)						office 281. LOCATION (Street end Number or Rural Route Number, City or Town, State)					
COMPLETED	29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basic of my knowledge, death occurred at the time, date end place, end due to the cause(e) end menner ee stated.											
H	290. SIGNAPORE AND TITLE OF CENTIFIED	25	>				Dala	WER		29d. DATE	SIGNED (M	onth, Day, Year)
<u>و</u> ا	want of the							-		- 0	ctobe	er 20,1995

PERSON WNO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print)

Peter M. Schissler, M.D. 7500 Greenway Ctr. Drive, #430 Greenbelt, Md. 20770

31. DATE FILED (Month, Day, Year)

32 REGISTRAR'S SIGNATURE
Sulia Davidson Randall

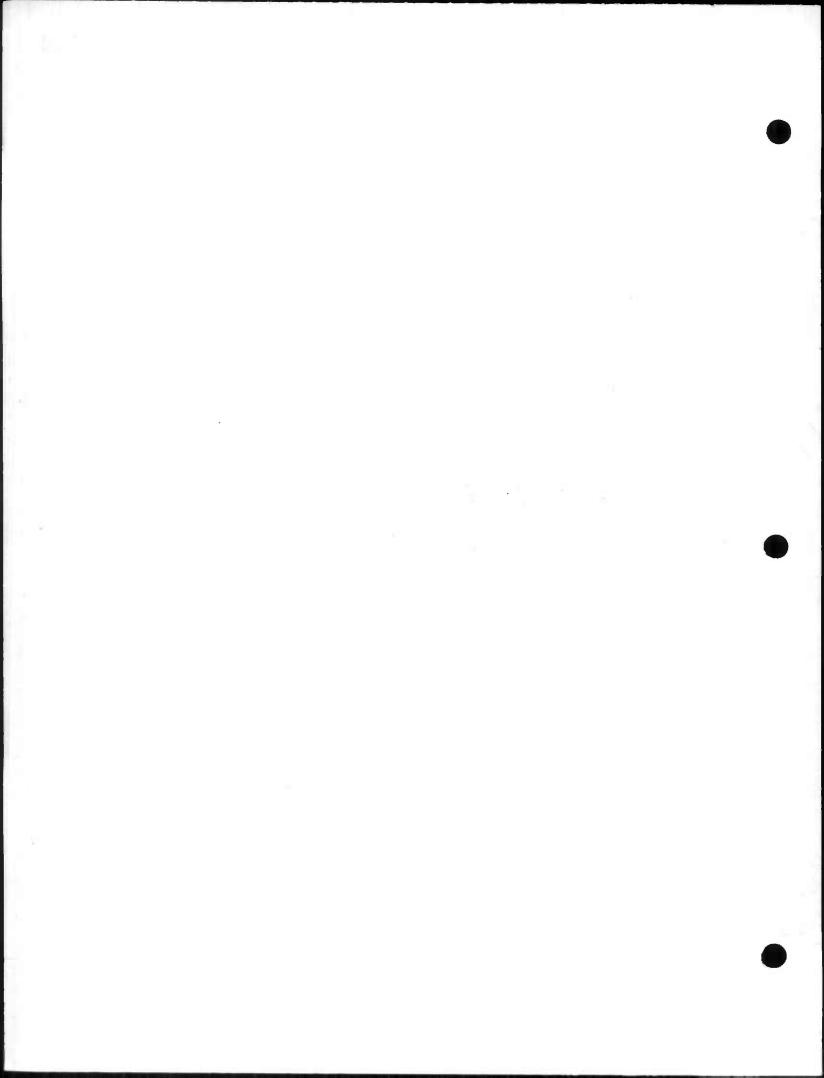
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, crientalon, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR				CERTIF	ICALI	E Or	DEA	l m		REG. NO.						
	1. DECEDENT'S NAME (First	DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH MONTH DAY YEAR 3. TIME OF DEATH															
	AHMED HASHEMI HAERI												8:47 P M				
	4. SOCIAL SECURITY NUME 577-62-0705		5. SEX 1 XM 2 F	6. AGE (In yrs	4 YRS.	IF UNDER	DAYS	HOURS	MIN.	7. DATE (21,19	41	8, BIRTI Count LT	HPLACE (State or Foreign Try) an			
	9a, FACILITY NAME (If not in	nstitution, give st	reet end number)			9b. CITY	y, TOWN	OR LOCATI	ON OF DE	ATH		9c. COU	INTY OF	DEATH			
DIMECTOR	THE JOHNS HOPKINS HOSPITAL					BALTIMORE CITY						N/A					
	RESIDENCE OF DECEDENT					TY, TOWN OR LOCATION					10d. INSIDE CITY LIMITS?						
- 10	Maryland Montgomery F						otomac 101, ZIP CODE					1 10g, CITIZEN OF WHAT COU					
UNERAL	8804 Maybe	20854					U.S.A.										
5	11. MARITAL STATUS	13. WAS DECENDENT OF HISPANIC ORIGIN If yea, specify Cuban, Mexican, Puerto								E - American Indian,							
10	1 Never Merried 2 Married FQRCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES						1 YES 2 X NO Specify:					Specify: white					
3		(Specify only highest grade completed) (Give kind						of work done during most of working					16b. KIND OF BUSINESS/INDUSTRY				
COMPLE	Elementary/Secondary (I	Elementary/Secondary (0-12)					We Do NOT use retired.)					construction firm					
	17. FATHER'S NAME (First, A	Aiddle Lest)	3	Jai	Curre	36		18 MOT	THER'S NAME (First, Middle, Meiden Surname)								
	Ali Hasher		i							Shake		,					
D BE	190, INFORMANT'S NAME (er, City or Towi			051			
-	Mary Fate		eri						, Po	_	e, Mar						
	20e. METHOD OF DISPOSIT 1 (XBurlal 2 Crematic 4 Donation 5 Other	on 3 🗆 Ramo	oval from State	cemeters	CEANDDATE r, cremetory or t klawn	other plece	1		t.24	95				own, State Maryland			
	21. SIGNATURE OF FUNDINA	AL SERVICE LIC	ENSEE	111	7	22.	NAME :	AND ADDRE	SS OF FA	CILITY							
	DeVol Funeral Home 2222 Wisconsin Ave., N.W., Wash., DC 20007												DC 20007				
2	IMMEDIATE CAUSE (FI disease or condition resulting in death)	neart failure.	List only one car	use on each	line.							Tallory an		Approximate Interval Batween Onset and Death			
CEMINICATION	Sequentially list conditions, if any, laading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE QF): DUE TO (OR AS A CONSEQUENCE QF):																
EDICAL C	PART II. Other algoritics	PERFORMED? AMILABLE PRIOR TO COMBLETION DE CAUSE										b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE					
_		1 U YES 2 1									₽ NO	OF DEATH?					
2	DID TOBACCO U	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO Y UNCERTAIN															
3	EXAMINER?	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: OTHER:															
2	1 TYES 2 THO		1 (Inpatient 2			4 □ Nu	irsing H	ome 5 🗆 R	lesidence	Y			2011272				
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 26. PLACE OF DEATH (Check only one) 27. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 VES 2 VIO 28. PLACE OF DEATH (Check only one) 29. PLACE OF DEATH (Check only one) 20. Accident S Pending Investigation 20. Accident S Pending Investigation 3 Suicide S Could not be determined determined 4 Homicide determined										COMED	ED						
										Route Number,							
COMPLETED												11177 m					
M	(Check only		CIAN: To the best of R: On the basis of											(e) end manner ee stated.			
	20. SIGNATURE AND TITLE OF CERTIFIER							An Lucelos Million						ONED (Month, Day, Year)			
Moah behtyi, MO Medicine Resident M6316 Doctober, 21,																	
	30. NAME AND ADDRESS O	F PERSON WH	Johns 1	USE OF DEATH	(ITEM 27) (Typ	e, Print)	1, 1	0466	110	Bali	imo re	MI	9	21287			
	31. DATE FILED (Month, Day)	; Year)	32. REGISTR	AR'S SIGNATU	RE		,										
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BALTIMORE, MARYLAND 21215-0020	if 24 hours after death. Page 6 may be retained to
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IVISION OF VITAL RECOR	3 ATTENDING PHYSICIAN: The law requires that
DIVISION OF VITAL RECORDS, P.O. BOX 68760	OR ATTENDING PHYSICIAN: The law requires that

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

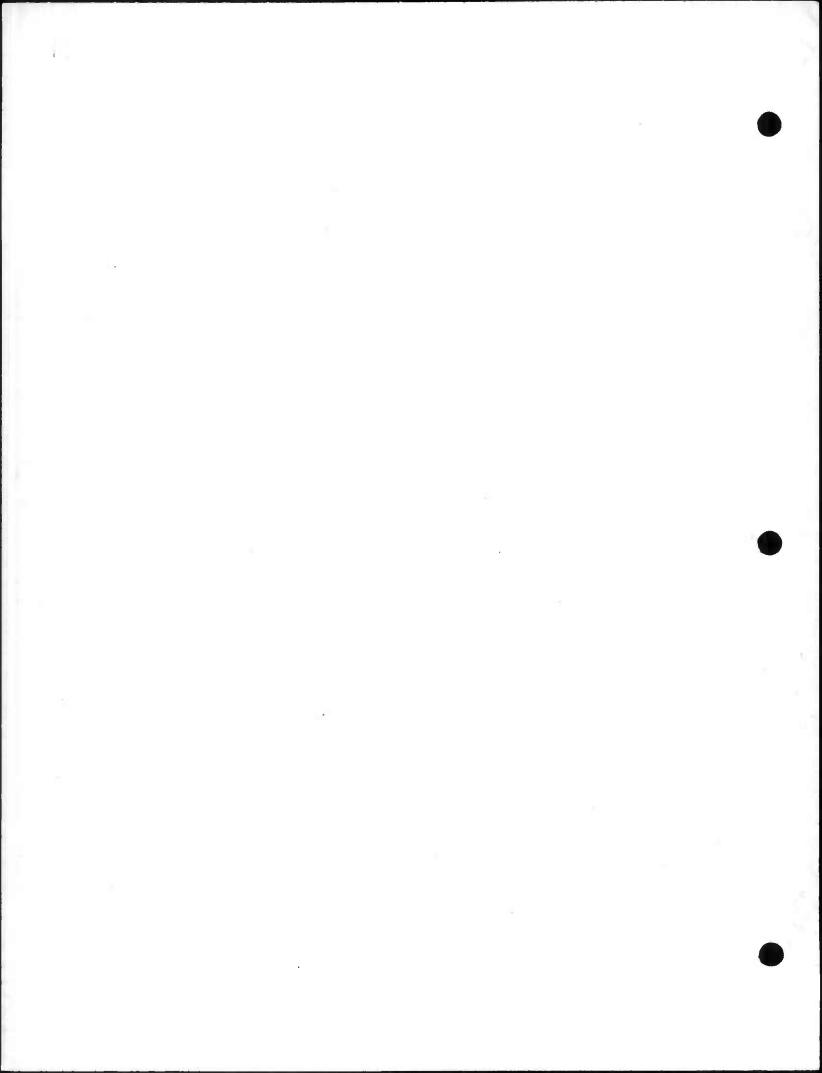
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF DEATN		3. TIME OF DEATH				
	Kevin Newell Henn	esse	YS				Detober	95 11:20 P M					
		birthday) IF	UNDER 1 YEAR		24 HRS.	7. DATE OF BIRTH	8. BIRTNPLACE (State or Foreign						
	405-54-3876 1፟፟፟ № 2 🗆 ғ	54	YRS. MONTHS DAYS HOURS MIN				May 5, 19	41	Country) Minnesota				
	Be. FACILITY NAME (If not institution, give street and number)		96	CITY, TOW	N OR LOCATIO				NTY OF DEATN				
FUNERAL DIRECTOR	4112 Everett Street			Kens	ington	l.		Moi	ntgomery				
EC	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		10c, CITY, TO	OWN OR LO	CATION				10d. INSIDE CITY				
PHO	Maryland Montgomery			singt					LIMITS?				
AL.	100. STREET AND NUMBER		- ACH		101. ZIP CODE	_		10a, CIT	IZEN OF WHAT COUNTRY?				
ER.	4112 Everett Street				208	95			USA				
N N	11. MARITAL STATUS 12. WAS DECEDENT EVER 1 Name Married 2 N Married FORCES? 1 YES	IN U.S. ARI	MED	13. WAS D	ECENDENT OF	NISPANIC	ORIGIN? (Specify Yes	or No-	14. RACE — American Indian.				
ВУ	IF YES, GIVE WAR OR	DATES			ES 2 K NO		Puerto Rican, atc.)		Black, White, atc. Specify:				
	3 Widowed 4 Divorced Vietna 15. DECEDENT'S EDUCATION		CEDENT'S USU	1			1		White				
	(Specify only highest grade completed)	/G/s	re kind of work Do NOT use ret	done during	most of working	,	16b. KIND OF BUS	INESS/INE	DUSTRY				
COMPLETED	Elementary/Secondary (0-12) College (1-4 or 5+) 5+	Pl	nysici	an			Medica:	1					
ő	17. FATHER'S NAME (First, Middle, Lest)				16. MOTNE	ER'S NAME	(First, Middle, Maiden :	Surname)					
BE (Newell Patrick Hennessey				Dor	othy	Wickert						
2	19e. INFORMANT'S NAME (Type/Print)	19b.					ite Number, City or Town						
-	Margaret Hennessey		4112	Evere	tt Str	eet,	Kensingto	on, l	MD 20895				
	20e. METHOD OF DISPOSITION 1 Burlet 2 Cremetion 3 Removal from State	b. PLACE A	NO DATE OF DI	SPOSITION	Name of		DATE 20c. LOC	CATION -	City or Town, State				
	4 Donation 5 Other (Specify) M. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE	etrop	olitar	Crei	natory	10/2	5/95 Alexandria, VA						
	· m 1 01	1		Fran	cis J.	Col:	lins Funer	ral H	Home, Inc.				
	Offather Jilal			500	Univer	sity	Blvd.W.	Sil.9	Spr.MD 20901				
	23. PART I. Enter the diseases, or complications that ceuse shock, or heart failure. List pniy one cause on	ed the dea aach iine.	ith. Do not e	enter the r	node of dyin	ig, auch i	na cardiac or reapir	ratory an	reat, Approximata interval Between				
	IMMEDIATE CAUSE (Final												
	disease or condition a. MeTasTATIC COLON CANCER TUGGIS												
_	DUE TO (OR AS A CONSEQUENCE OF):												
Ö	Sequentially list conditions, If any leading to immediate Due to (OR AS A CONSEQUENCE OF):												
S	ri airy, reacing to immediate												
H	CAUSE (Disease or Injury that initiated events DUE TO (OR AS A CONSEQUENCE OF):												
H	d.												
MEDICAL CERTIFICATION	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY FINDINGS PERFORMED? AMILIABLE PRIOR TO												
DIC.						_ 1 TYES 2		MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?					
ME									1 TES 2 TO NO				
ž	DID TOBACCO USE CONTRIBUTE TO CAUSE (_	RTAIN			0.2				
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL:	26. PLACE	OF DEATH (C	heck only on	0)								
17S	1 YES 2 10 1 Inpatient 2 ER/Out 27. MANNER OF DEATH 28e. DATE OF INJURY	tpatient 3 (DOA 4	Nursing No			Other (Specify)						
	1 Natural 5 Pending (Month, Day, Year)		28b. TIME OF INJURY		NJURY AT VORK?		8d. DESCRIBE HOW IN	JURY OCC	CURED				
В	2 Accident Investigation 3 Suicide & Could not be 28e. PLACE OF INJUR	Y — At hor	ne, ferm, street		YES 2		8t. LOCATION (Street ar	nd Ahimbac	as Royal Courts Number				
回	4 Homicide 6 Could not be building, atc. (Spe	ecify)		,,			City or Town, State)	id Humbur	or ridial ribble ribble,				
COMPLET	29a. CERTIFIER Check may Check my known control of the best of my known control of the best of my known control of the best of my known control of the best of the	vledge des	th occurred at	the time de	de and place of	and due to	the course(s) and man						
M I	(Check one) The beat of my known one) The beat of axamination one)												
	296. SAMPATURE AND STILE OF CERTIFIER	m	X		290 LICEN				E SIGNED (Month, Day, Year)				
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	INTOMIS IT. BENSINGER 75	525	GRE	ENIU	DU CI	o. Do	Pivo GRI	BBN	BELT MD 20770				
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	OCT 26 1995 July Davidson Ra	roall											
					_				DMMH 46 B 400				



1. DECEDENT'S NAME (First, Middle, Last)

1 - FOR STATE REGISTRAR

3. TIME OF DEATH

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	OR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit, Pages 1, 2, 3		
TENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	burial-transi		
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TENDIP	DR. At	fter de	1 S S

2. DATE OF DEATH OCT . 1 1995 18, 0428 AM ELMA MAE IREY 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH
(Month, Day, Year)
May 12,1905 5. SEX B. AGE (In yrs. lest birthday) 8. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR IF UNDER 24 HRS. DAYS 1 - M 2 F HOURS MIN. 233-26-0181 Virginia phould 9a. FACILITY NAME (If not institution, give street end number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 118 CAROL AVENUE HARFORD **ABERDEEN** 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d, INSIDE CITY Maryland Harford Aberdeen 1- YES 2 NO 10e. STREET AND NUMBER FUNERAL 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 118 Carol Avenue 21001 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No -14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Merried If yes, specify Cuben, Mexican, Puerto Rican, atc.) t TYES 2 NO Specify: Specify: BY 3 Widowed 4 Divorced White ETED 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondery (0-12) College (1-4 or 5+) COMPL 12 Chief Operator of Signal Corp. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surneme) Clinton Miller Grace Redmond BE 190. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Mr. Donald L. Irey 812 Marcie Ct., Bel Air, Maryland 21014 20a. METHOD OF DISPOSITION
1 Secretaria Burlei 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION -- City or Town, State cemetery cremetery or other place).
Harford Memorial Gardens Donetion 5 C Other (Specify) 10/23 Aberdeen, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Tarring-Cargo Funeral Home, P.A. Kirsten Ma Aberdeen, Maryland 21001-3399 23. PART I. Enter the diseases, or complications that caused by death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata shock, or heert feilure. List only one ceuee on each line. Interval Batween Onset and Death **IMMEDIATE CAUSE (Finel** disease or condition Injuries Thermal resulting in death) DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in deeth) LAST PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PERFORMED? AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 PYES 2 NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\Boxed{1}\) NO \(\Boxed{1}\) UNCERTAIN \(\Boxed{1}\) PHYSICIAN: 28. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL HOSPITAL: OTHER: 1 YES 2 | NO HOSPITAL:
1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5X X seeldenca 8 ☐ Other (Specify) 28a. DATE OF INJURY (Month, Day, Year) 10 - 18 - 95 27. MANNER OF DEATH 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED Subjet poured influences to gount on self 1 set self on pre 1 Natural 5 Pending Investigation 1 TYES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, farm, atreef, fectory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide 8 Could not be COMPLETED 4 Homicide TO THE HOSPITAL DR ATTE TO THE FUNERAL DIRECTOR DE filed within 72 hours afte IMPORTANT: If Item 28 Residence outside 118 Carol 29e. CERTIFIER
(Check only one)

Tymenical Evamines: On the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end men ** MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, 29b. SIGNATURE AND TITLE OF CENTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE ▶ OCT. 19,1995 O.C.M.E 9 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 owler 31, DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE OCT 23 1995 John Shucker Re

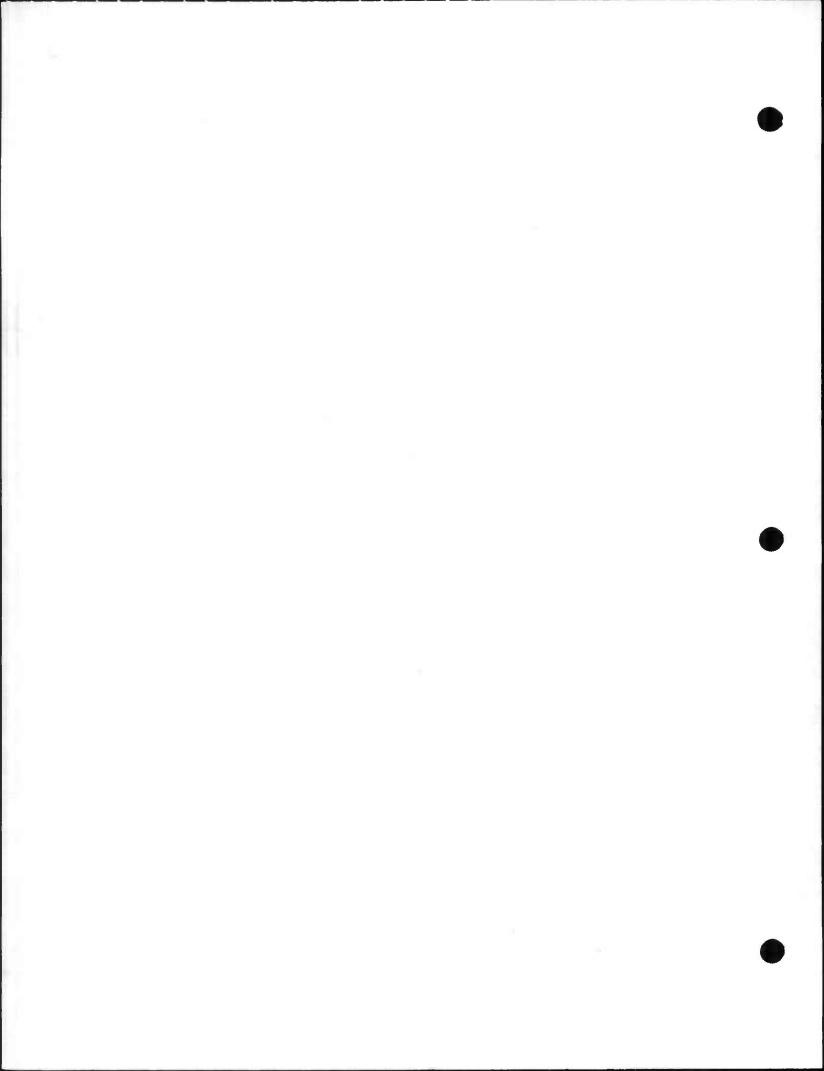
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE **CERTIFICATE OF DEATH**

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FINERAL DIRECTOR: After this certificate has been stoned by the attending physician and compalenty filled in by the humanal director name 5, should be desprived for use as the humanal sounds by the attending physician and compalenty filled in by the humanal director name 5, should be desprived for use as the humanal sounds.	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunial, cremation, or removal. IMADICTABLE If here 26 is marked or Nam 23 shows any Indianal or other demandal annual the marked or Nam 29 shows any Indianal or other demandal annual to a state of the state
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FOR STATE REGISTRAR	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.		

	STATE REGISTRAR 1. DECEDENT'S NAME (First, Middle, Last.)			CERTIF	ICATE			ГН	REG. NO).		
ľ	LUCIUS C.	JARVI	S							AY 20	YEAR 95	12:35 A M
	4. SOCIAL SECURITY NUMBER	5. SEX	¥	rs. lest birthday)	IF UNDER	t YEAR	IF UNDER	24 HRS.	7. DATE OF BIRTH		O. BIRTHPL	ACE (State or Foreign
	717-09-0786	1 🔀 M 2 🗌 F	88	YRS.	MONTHS	DAYS	HOURS	MIN.	2-21-07		Country)	land
_	9e. FACILITY NAME (If not institution, give	atreet end number)			9b. CITY	TOWN 0	R LOCATIO	ON OF DE	ATH	9c. COUN	TY OF OEAT	
DIRECTOR	Williamsburg Ma	anor			W:	illi	amsb	urg		Dor	chest	er
Sign I	10e. STATE 10b. COUNT	TY		10c. CIT	Y, TOWN C	R LOCAT	ION				10	d. INSIDE CITY
ā	Maryland Dor	chester		Ro	seda	le						LIMITS?
₹ I	10a. STREET AND NUMBER					101.	ZIP CODE			10g. CITIZ		T COUNTRY?
FUNERAL	5908 Reliance						2165	9		U.	S.	
₽	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDEN FORCES? 1 IF YES, GIVE Y	YES :	2 NO		f yes, spe	ENDENT Oncify Cuba	n, Maxican	C ORIGIN? (Specify Ye., Puerlo Rican, etc.)	s or No—	Black, W	American Indian, Thite, etc.
	15. OECEDENT'S EDI (Specify only highest grad		16	Give kind of	USUAL O	CUPATIO	N of working		16b. KIND OF BU	SINESS/INDL	JSTRY	
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COMPL	17. FATHER'S NAME (First, Middle, Last)			Dispa	tche	r			Public '		orta	tion
S	William J. Jar								NE (First, Middle, Melden			
	190. INFORMANT'S NAME (Type/Print)	VIS		19b. MAILING	ADDRESS	(Street e			ine Ann So		Codel	
2	Betty Lou Hope	- Niece							osedale, l			1659
İ	20a. METHOD OF DISPOSITION 1 ☐ Burlet 2 X Cremetion 3 ☐ Rer			ACE AND DATE	OF DISPOS				DATE 20c. LO			
	4 Donaston 5 Dother (Specify)	1	Carreta	oitol (rema				21/95 Do	ver, I	De.	
	21. SIGNATURE OF FUNERAL SERVICE A	CENTRY	de				O AODRES		ury eral Home			
	John A. Cra		2000			P O	Box	967.	Seaford.	De. 1	19973	
	23. PART I. Enter the diseases, or ahock, or heart failure.	complications the	at caused thuse on each	a death. Do r	not enter	the mod	da of dyl	ng, such	aa cardiac or reap	iratory arre	at,	Approximata Interval Between
	IMMEDIATE CAUSE (Final disease or condition)							Onset and Death
H	resulting in death)	a.	Remo	INSEQUENCE OF	cen	cer						10 mo
.	_	DUE 10	OH AS A CO	MSEQUENCE OF	F):							F
9	Sequentially list conditions, if any, leading to immediate	b. DUE TO	(OR AS A CO	NSEQUENCE OF	F):							İ
5	cause. Enter UNDERLYING CAUSE (Disease or Injury	с										
	that initiated events DUE TO (OR AS A CONSEQUENCE OF):											
CERTIFICATION	resulting in death) LAST											
CALC	PART II. Other eignificant condition	ns contributing to	death but	not resulting	n the un	derlying	cause g	iven in F	Part I. 24a. WAS AN			RE AUTOPSY FINDINGS
	Congestive 6	Jeant J	alu	e					PERFOR	. /	co	AILABLE PRIOR TO IMPLETION OF CAUSE DEATH?
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	DID TOBACCO USE CONT	RIBUTE TO CA					UNC	ERTAIN				
SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		PLACE OF DEAT	OTHER	1:		/				
PHYS	1 YES 2 NO	1 Inpatient 2 28e. DATE OF		nt 3 DOA		ing Home		_	Other (Specify) 28d. DESCRIBE HOW I	ALILIEN COOL	1050	
à l	1 Natural 5 Pending 2 Accident Investigation	(Month, D	Pay, Year)		M.	1 Y	RK? ES 2	NO NO				
ETED	4 Homicide datermined	building,	atc. (Specify)	The tracking full fig. 1	arrest, tact	ry, office			28t. LOCATION (Street of City or Town, State)	ena Number o	r Plurai Plouti	Number,
COMPL	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYS								o the cause(e) and mai me, data and place, en			d manner es stated.
BE	29b. SIGNATURE AND TITLE OF CERTIFIE	4 20	2res	0			29c. LICE	NSE NUME)73	29d. DATE	SIGNED (MO	onth, Day, Year)
일	30. NAME AND MODES OF PERSON WE	O COMPLETED CAU	SE OF DEATH	(TLEM 27) (Type,	Print)		_				1	4
	31. DATE FILED (Month, Day, Year)	L. MET	RESIDENTIATION AL RESIDENTIA	NO	50	3 1	3/2	W E	ST CAM	BRID	YE.	Mel HLB



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BALTIMORE, MARYLAND 21215-0020

Amended item # 1 WCHD jrd 10/19/95 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH 1. OECEOENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 1995 OCTOBER 12, RAYMOND 6:55 **JAMES** Рм 4, SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year) 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS. 6. BIRTHPLACE (State or Foreign 1 M 2 - F 23 263-51-9724 YRS. Aug. 10,1972 Florida 9s. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c, COUNTY OF DEATH DIRECTOR PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10a. STATE 10d. INSIDE CITY 1 X YES 2 NO Wicomico Salisbury MD FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? United States 21801 709 W. Isabella Street 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 VES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE - American Indian, Black, White, atc. 1X Never Married 2 Married If yes, specify Cuben, Maxican, Puerto Rican, etc.) 1 YES 2 XNO Specify: BY 3 Widowed 4 Divorced Black 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working COMPLETED 15. DECEDENT'S EDUCATION pecify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY (Spi (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) 9th grade 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname) Linda Rivers Willie Charles Shramp BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code, 2 Isabella St., Salisbury, MD 21801 Linda Rivers 709 W. 20s. METHOD OF DISPOSITION
1 💢 Buriel 2 □ Cremation 3 □ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State OATE 10/21 4 Donation 5 Other (Specify) Cottage Grove Cemetery Westover 21. SIGNATURE OF PUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Lewis N. Watson Funeral Home 1618 West Rd., Ext., Salisbury, 21801 MD 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Approximata intarvai Between shock, or heart fellure. List only one ceuse on each line. Onsat and Death IMMEDIATE CAUSE (Final disease or condition resulting in deeth) houd Shot hound DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF): if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initisted events resulting in deeth) LAST PART ii. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part i. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PERFORMED? AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\Boxed{1}\) NO \(\overline{2}\) UNCERTAIN \(\Boxed{1}\) PHYSICIAN: 26. PLACE OF OEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL HOSPITAL:

1X Inpetient 2 - ER/Outpetient 3 - DOA **EXAMINER?** OTHER: 1 X YES 2 - NO 4 Nursing Home 5 Realdence 6 Other (Specify) 28s. OATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28b. TIME OF INJURY 28c, INJURY AT WORK? 28d. OESCRIBE HOW INJURY OCCURED Subject 1 Natural 16 45 M 5 Pending 1 YES 2 NO 10/10/1995 ВУ 2 Accident
3 Suicide 28s. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be COMPLETED 4 Homicide MO 29s. CERTIFIER (Check only one)

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

X YMEDICAL EXAMINER: On the basis of examination and/or investigation. In my online, death occurred at the time, date and place, and due to the cause(s) and manner as stated. X XMEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated, 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 8 OCTOBER 14, 1995 O.C.M.E. 2 30. NAME AND AGORESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

hours 2 executed 20 DIVISION OF VITAL RECORDS, OR ATTENDING PHYSICIAN: The law TO THE HOSPITAL
TO THE FUNERAL (
be filed within 72 h
IMPORTANT: If it HOSPITAL

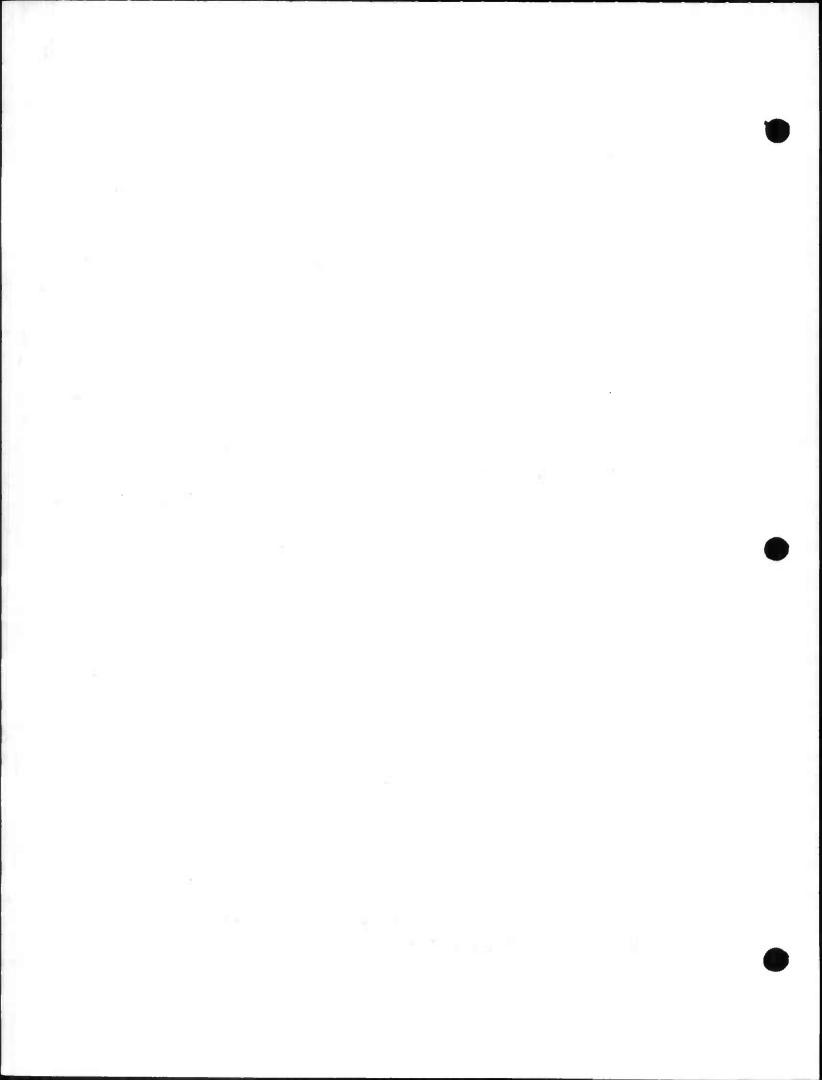
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31. DATE FILED (Month, Day, Year)

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached to	be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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	FOR STATE REGISTRAR	TATE OF MAR			TMENT O			MENTAL HYGIE			
	1. DECEDENT'S NAME (First, Middle, Last)							2. DATE OF DEATH			3. TIME OF DEATH
1	STEVEN MIC	HAEL JO	HNSTO	N				OCT. 1	5,199	5	0022 M
	4. SOCIAL SECURITY NUMBER 5. S	EX 6. A	AGE (in yrs. last	birthday)	IF UNDER 1 YE	AR IF UNO	ER 24 HRS.	7. DATE OF BIRTH		O. BIRTH	IPLACE (State or Foreign
	168-60-0196	M 2 🗆 F	19	YRS.	MONTHS DA	YS HOURS	MIN.	April 17, 19	976	Pen	msylvania
	9a. FACILITY NAME (If not institution, give street as	nd number)			9b. CITY, TO	WN OR LOCA	TION OF DI		9c. COUNT		
DIRECTOR	PENINSULA REGIONAL MEDICAL CTR. SALISBURY RESIDENCE OF DECEDENT WICOMICO										
12	10a, STATE 10b, COUNTY			10c. CIT	Y, TOWN OR L	DCATION					10d, INSIDE CITY LIMITS?
盲	Maryland Wicomi	ico		S.	alisbu	ry					1 YES 2 XNO
A P	10e. STREET AND NUMBER					10f. ZIP CC	DE		10g. CITIZ	EN OF Y	VHAT COUNTRY?
E	8236 Arden Dr.					2 1	801			USA	
FUNERAL		WAS DECEDENT EV						NIC ORIGIN? (Specify)	ea or No —	14. RACE	E — American Indian, k, Whita, etc.
	1 □ To Lidade, West, led 5 □ West, led	F YES, GIVE WAR O		0		F, specify Cur YES 2 X N		in, Puerlo Ricen, etc.) ly:		Speci	
ВУ	3 Widowed 4 Divorced										ite
	15. DECEDENT'S EDUCATION (Specify only highest grade complete)		(Gh	ve kind of v	USUAL OCCU	PATION a most of wor	rkina	16b. KIND OF B	USINESS/INDU	STRY	
l iii	Elementary/Secondary (0-12) Col	lege (1-4 or 5+)	life.	Do NOT us	se retired.)						
MP	12 1		S	tude	nt			Commun	ity Co	lle	ge
COMPLETED	17. FATNER'S NAME (First, Middle, Lest)					18. MC	THER'S NA	ME (First, Middle, Maide	n Sumame)		
ш	Paul R. Johnston S	Sr.				M	ary	K. Orr			247
10 B	19a. INFORMANT'S NAME (Type/Print)		19b	, MAILING	ADDRESS (St	reet and Numi	ber or Rural	Route Number, City or To	own, State, Zip (Code)	100
F	Paul R. & Mary John	nston		8236	Arden	Dr.,	Sali	sbury,MD	2 180 1		
	20s. METNOD OF DISPOSITION 1 Burial 2 2 Separation 3 Removal to	rom State	comptoni arei	matarı ar a	OF DISPOSITIO				OCATION — C		
	4 Donation 6 Dother (Specify).	eroki e	Salis	bury	Crema			10/18 Sa	alisbu	ry,	MD
-	21. SIGNATURE OF FUNERAL SERVICE LICENSE	1			22. NAI	E AND ADDI	RESS OF FA	ineral Hom	0		
	> A lought	1/2						11 Rd., S		1	MD 21801
	23. PART I. Enter the diseases, or comp	lications that car	upod the de	eth Do							Approximate
	shock, or heart failure. List of IMMEDIATE CAUSE (Final disease or condition	only one cause	on each line.	0	c:		,,		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Interval Between Onset and Death
	resulting in desth) a	DUE TO (OR	AS A CONSEC	UENCE O	yeur	(6)					
z			V		-						
CERTIFICATION	Sequentially list conditions, if any, lesding to immediate	DUE TO (OR	AS A CONSEC	DUENCE O	F):						
S	CAUSE (Disease or Injury										
E	that initiated events	DUE TO (OR	AS A CONSEC	DUENCE O	F):						
	resulting in desth) LAST										
0	PART II. Other significant conditions cor	ntributing to des	ath but not re	esulting	In the under	lylng caus	e given in	Part 1 24a WAS	AN AUTOPSY	246	, WERE AUTOPSY FINDINGS
S			-117 500 1100 11	oounting	in inc ando	lynig cada	given in	PERF	ORMED?	240	AVAILABLE PRIOR TO COMPLETION OF CAUSE
ä								1 XO ES	2 NO		OF DEATN?
Σ	DID TODA CCO LICE CONTRIBU	ITE TO CALLC	5 O5 D5 A	T14 \/			LOEDTAL				TYPYES 2 NO
PHYSICIAN: MEDICA	DID TOBACCO USE CONTRIBU	JIE 10 CAUS					ICERTAI	N YEA			
0		SPITAL:	28. PLAC	E OF DEA	OTHER:	one)					
YS		Inpetiant 2 XER					Rasidenca	8 Other (Specify)			
표	27. MANNER OF DEATN 1 Netural 5 Pending	(Month, Day, Y		28b. TIM	JURY	:. INJURY AT WORK?		28d. DESCRIBE NOV	CONCE	URED	cau, s. and
BY	2 Accidant Investigation	10.14		235	70		ЖОНО	a contract	POL	E	
8	3 Suicide 6 Could not be 4 Nomicide determined	26a. PLACE OF IN. building, stc.	(Specify)	me, farm,	etreet, tactory,	offica		26t, LOCATION (Street) City or Town, Sta	(0)		
	Nomicios Ostamines		5	STR	201			144346	Pittsus	11/e	-
COMPLET	29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN:	To the best of my	knowledga, da	ath occum	ed at the time	data and pla	ice, and du	e to the cause(a) and n	namer aa atste	d.	
O	MEDICAL EXAMINER: On	the basis of axami	ination and/or i	investigation	on, la my opia	on, desth oc	cured at the	time, data and placa,	and dua to the	cause(s) and menner as stated.
	29b. SIGNATURE AND TITLE OF CENTIFIER					29c. L	ICENSE NU	MBER	29d. DATE	SIGNED	(Month, Day, Year)
BE		m				0	.C.M	. E			15,1995
2	30. NAME AND ADDRESS OF PERSON AND COM	MILETED CAUSE O									
	Monx	M	111	Pen	n Str	eet,	Bal	timore,	Maryl	and	21201
	31. DATE FILED (Month, April, Worl)	32. PEGISTRAR'S	SIGNATURE								
	UCT 1 7 1995	Jalia Daw	whor has	dallo							

ial-transit permit. Pages 1. 2. 3 should

TO BE COMPLETED BY FUNERAL DIRECTOR

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within express a hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-trans be filled within 72 hours after death with the State Detot, of Health and Mental Hydiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once,
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certific	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fit be filled within 72 hours after death with the State Degr. of Health and Mental Hydiene prior to burlal, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other

BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

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Sequentially list conditions,

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6 Could not be determined

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	1 - FOR STATE REGISTRAR		STATE OF I	MARYLAN	D / DEP					MENTAL HYGIEN REG. NO.	E			
	1. DECEDENT'S NAME (First, Mid	idle, Last)			•					2. DATE OF DEATH			3, TIME OF OEATH	
	CHARLES		J	ESTE	R			OCTOBER 1	ř. 1	995	1:46 PM			
	4. SOCIAL SECURITY NUMBER		5. SEX	8. AGE (In)	rs. last birthde	ey) IF UNC	ER 1 YEAR	IF UNDE	24 HRS.	7. DATE OF BIRTH		7	HPLACE (State or Foreign	
	215-18-4633		1 🙀 M 2 🗌 F	73	YRS	MONTH:	DAYS	HOURS	MIN.	(Morith, Day, Year) May 29, 1	922	DE	**	
	9e. FACILITY NAME (If not institut	tion, give st	reet and number)			9b. CI	TY, TOWN O	R LOCAT	ON OF DE			UNTY OF	DEATH	
	THE JOHNS HO		S HOSPIT	CAL		F	BALTI	10RE	CIT	Y	В	alti	more	
1	RESIDENCE OF DECED												mo I C	
		Susse			10c.		OR LOCAT	ION					10d. INSIDE CITY LIMITS?	
	10s. STREET AND NUMBER	Susse	X			Lauı							1 TYES 2 NO	
							101	ZIP COD	E		10g. CIT	TIZEN OF	N OF WHAT COUNTRY?	
	Rt# 3 Box 164	4						1995	5	USA			1	
	1 Never Married 2 X Men	11. MARITAL STATUS 1 Never Married 2 X Merried 3 Widowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 VES 2 X NO IF YES, GIVE WAR OR DATES						13. WAS DECENDENT OF HISPANIC Of If yes, specify Cuban, Mexican, Pt. 1 YES 2 NO Specify:				an, Puerto Ricen, atc.) Black, White,		
	15. DECEDEI (Specify only high	NT'S EOUC heat grade (completed)		(Give kind	of work don	s USUAL OCCUPATION f work done during most of working use retired.) Metal			16b. KIND OF BUS				
	Elementary/Secondary (0-12)		College (1-4 or 5 -		Sheet					Yachi				
	17. FATHER'S NAME (First, Middle	Last)						18. MOT	HER'S NA	AE (First, Middle, Meiden Surname)				
	Thomas B. Jes	ster					Effie Calloway Jester							
ı	19e. INFORMANT'S NAME (Type/F	Print)	-	-	19b. MAIL	ING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)								
	Helen I. Jest	ter			1	t. #3 Box 164 Laurel, De. 19956								
	20a. METHOD OF OISPOSITION 1 M Burlel 2 □ Cremetion 3 □ Removal from State 20b. PLACE AND OATE complexy, cremetory or or						DATE OF DISPOSITION (Name of DATE 20c LOCATION — City or Town, State							
	21. SIGNATURE OF FUNERAL SE		22. NAME AND ADDRESS OF FACILITY Short Funeral Home, Inc. 700 W. St. Laurel, De. 19956						.11					
	23. PART I. Enter the disea	sea, or co	omplications that	t caused th	e death. D	o not ent	er the mo	de of dy	ing, suci	n as cardiac or reapi	ratory ar	reat,	Approximeta	
	IMMEDIATE CAUSE (Final disease or condition reaulting in death)	a a	Hook	amn	nonja	e	ncep	hal	opa	Alry			interval Between Onset and Death	
	1		TO BUE TO	NSEQUENCE	OF):		1		1					

if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease Dr injury urnhoso that initiated eventa DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO uamous 1 DES 2 NO

u (Cer

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH 25. WAS CASE REFERRED TO MEDICAL EXAMINER?

DUE TO (OR AS A CONSEQUENCE OF):

YES | NO | UNCERTAIN | 26. PLACE OF DEATH (Check only one) HOSB/TAL:
1 Description 2 ER/Outpatient 3 DOA OTHER:

COMPLETION OF CAUSE 1 TES 2 ...

28e. DATE OF INJURY (Month, Day, Year) ET. MANNER OF DEATH 28c. INJURY AT WORK? 28b. TIME OF INJURY 26d. DESCRIBE HOW INJURY OCCURED 1. Haturel
2 Accident
3 Suitide
4 Homicide 5 Pending Investigation 1 YES 2 NO

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

261. LOCATION (Street end Number or Rural Route Number, City or Town, State)

29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner es stated.

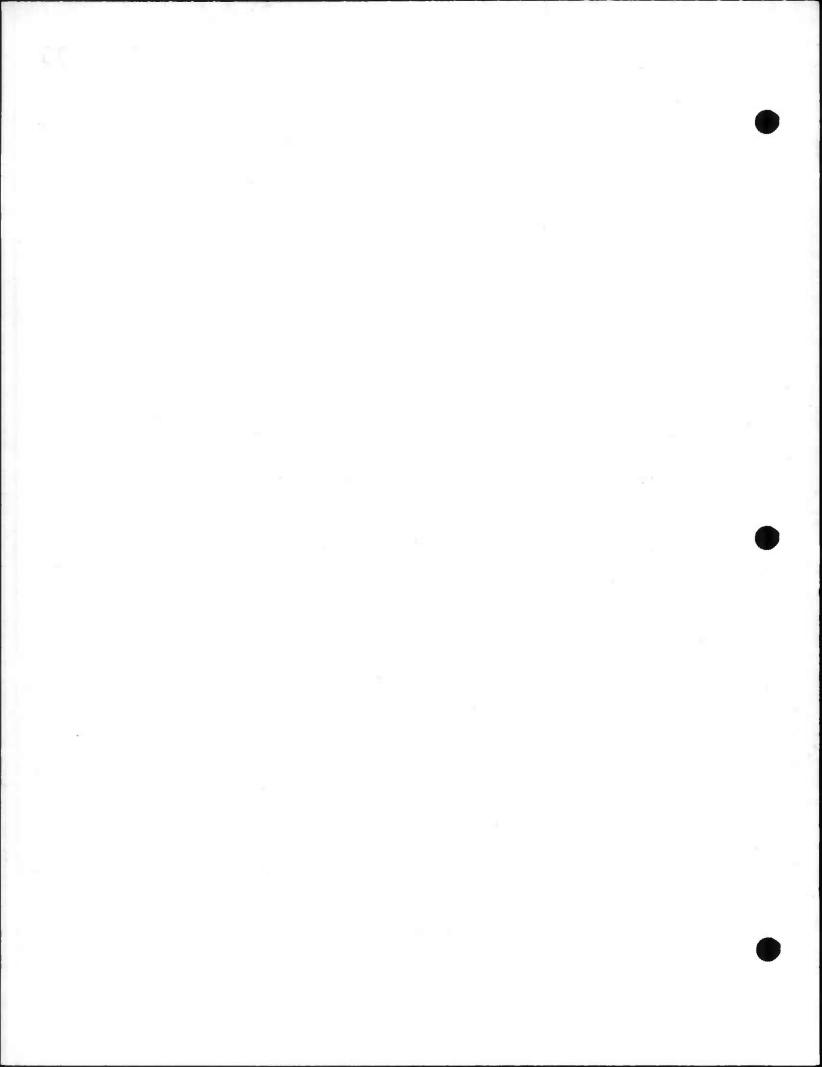
2 MEDICAL EXAMINER: On the basis	of examination e	nd/or investigation,	In my opinion, d	leath occured at	the time, date end p	elace, and due to the cause(e) end manner ae stated
	^^	-					

ng Home 5 🗆 Residence 6 🗀 Other (Specify)

96. SHOWATURE AND TITLE OF CONTIFIER SPACOV KON	Idon 29c. LICENSE NUMBER	29d, DATE SIGNED (Month, Day, Year)
Jerry Dustron Moz39	140239	Dotaber 11, 199

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)	/
Jerry Krishnan Johns Hopking	(Hospital 601 North Causine Street
31. DATE FILED (UCT 13 1995) 32 JEGISTRAD & SIGNATURE CANCELL	Suttemore Many lane

1



3. TIME OF DEATH

7:42 a.

10d. INSIDE CITY

RACE — American Indian, Black, White, atc.

Specify:

1 YES 2X NO

Interval Between

Onset and Death

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE

1 TES 2 NO

OF DEATH?

8. BIRTHPLACE (State or Foreign

м

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Lest)

	THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the hours after death. Page	die
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2. DATE OF DEATH DAY Dorothy E. October 3. 1995 Janey 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year) July 6, 1911 5. SEX 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 1 M 2 F 84 212-26-6743 Maryland use as the burial-transit permit. Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give atreet end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATN Edw.W.McCready Memorial Hospital Crisfield Somerset DIRECTOR RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 16c. CITY, TOWN OR LOCATION Maryland Somerset Princess Anne FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? Loretta Road 21853 USA retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, OIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIOIN? (Specify Yes or No—If yes, specify Cuben, Maxican, Puerto Ricen, atc.)

1 YES 2 NO Specify: 11. MARITAL STATUS 1 Never Married 2 Married ВҰ 3 🕅 Widowed 4 🗌 Divorced African American 15. DECEDENT'S EDUCATION ecify only highest grade completed) COMPLETED 18e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 166. KIND OF BUSINESS/INDUSTRY (Specify only highest P Elementary/Secondary (0-12) College (1-4 or 8+) 7th grade detached domestic housewife 17. FATHER'S NAME (First, Middle, Last) 16. MOTNER'S NAME (First, Middle, Meiden Surname) 2 Ħ UNKNOWN Beatrice Jackson notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 page 5 s E. Sarah Grady 4202, 58th Avenue, Apt. 318 - Bladensburg, MD 20710 may be must be 20e, METHOD OF DISPOSITION
1 🖒 Burlel 2 🗆 Cremetion 3 🗆 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE ctor, srael Memorial Cemetery 4 Donation Other (Specify) 10/6 Princess Anne, Maryland the medical examiner 21. SIGNATURE OF NUNERAL SERVICE LICENSES 22. NAME AND ADDRESS OF FACILITY Jolley Memoria Chapel 23. PART I. Enter the diseases, Dr completions that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feliure. List only one cause on sech line. 1213 Jersey Road - Salisbury, MD 21801 cremation, or diseese or condition Recuren resulting in death) traumatic event. DUE TO (OR AS A CONSEQUENCE OF) nding physician and cor Hygiene prior to burial, J'enerales CERTIFICATION Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury injury, or other DUE TO (OR AS A CONSEQUENCE OF) thet initiated avents resulting in death) LAST Mental PART II. Other eignificent conditions contributing to deeth but not resulting in the underlying cause given in Part I. PHYSICIAN: MEDICAL 24s. WAS AN AUTOPSY PERFORMED? of Health and N shows any 1 TES 2 NO Ulghermers DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN [Dept. Item 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) State HOSPITAL: OTHER: 1 TYES 2 TNO 1 S Inpetient 2 - ER/Outpetient 3 - DOA 4 - Nursing Home 8 - Residence 8 - Other (Specify) after death with the 28 is marked, or 27. MANNER OF DEATH 28e. DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED With 1 🔀 Natural 5 Pending ВУ 1 YES 2 NO death 2 Accident Investigation 28s. PLACE OF INJURY — At home, farm, atreet, fectory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide COMPLETED 8 Could not be hours after 4 Homicide Hem 29e. CERTIFIER

(Check only

1 🔀 CERTIFYINO PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner es stated. TO THE HOSPITAL
TO THE FUNERAL E
De filed within 72 h
IMPORTANT: If II 2 MEDICAL EXAMINER: On the basis of axamination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(s) and menner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE 29d. DATE SIONED (Month, Day, Year) Elgens D29505 (or) Oct 3, 1995 2 30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print)
Dr. Gregorio Belloso, Hall Highway, Crisfield, Md. 21817

32 RECISTRAR'S SIGNATURE

3 1995

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

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Pages 1, 2, 3 should

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	THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after	THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or remova
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 -CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH JACKSON OCTOBER DAY TRAVON L. 199 21 4:10 a 7. DATE OF BIRTH (Month, Day, Year) 9-27-19 4. SOCIAL SECURITY NUMBER 5. SEX IF UNDER 1 YEAR 1 (F M 2 | F 9a. FACILITY NAME (If not institution, give OB. CITY, TOWN OR LOCATE CRISFIELD 9c. COUNTY OF DEATH McCREADY MEMORIAL HOSPITAL DIRECTOR SOMERSET EDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d, INSIDE CITY LIMITS? SOMETSE TYES 2 NO FUNERAL 10e. STREET AND NUMBER tog. CITIZEN OF WHAT COUNTRY? 21817 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No If yes, specify Cuban, Maxican, Puerto Rican, atc.)

1 YES 2 NO Specify: 11. MARITAL STATUS 14. RACE Black American Indian 1 Never Married 2 Married BY 4 Divorced ETED. 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY ive kind of work done . Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) COMPL 17, FATHER'S NAME (First, Middle, Last, John Ħ BE notified 19a. INFORMANT'S NAME (Type/Print) 2 RUTH be 20a. MPTHOD OF DISPOSITION must 2 Cremation 4 Donetion 6 Other (Specify) examiner medicai 23. PART I. Enter the dispases, or complications that caused the death. Do not shock, or heart failure. List pnly one cause on each line. Interval Retween Onset and Death IMMEDIATE CAUSE (Final traumatic event, the disease or condition reaulting in death) DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF) If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury other t DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 Injury, PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL PERFORMED? AWAILABLE PRIOR TO any COMPLETION OF CAUSE OF DEATH? YES 2 NO Shows 729 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES | NO | UNCERTAIN | PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only) Item HOSPITAL 1 XYES 2 NO Inpatient 2X ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 0 28c. INJURY AT WORK? 27. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) Natural Accidant marked, 5 Pending Investigation ВУ 3 Sulcide 26e. PLACE OF INJURY - At home, term, street, factory, office .00 6 Could not be detarmined COMPLETED 28 TO THE HOSPITAL OR ATT TO THE FUNERAL DIRECTE be filed within 72 hours at IMPORTANT: If item 2 F CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner se stated. investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and menner se stated DATE SIGNED (Month, Day, Mear) 199 29c. LICENSE NUMBER BE O.C.M.E 2 PLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 60 CKE MO 111 Penn Street, Baltimore, Maryland 21201

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	TTEN	HOT.	28
	TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the house after death. Page 6 may be intained by the hospital or after	TO THE FUNERAL DIRECTOR: After this centificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use a find within 20 kind with	be med whilm 12 hours are used while base bebt. Or result and wend mydere prot to build, preliation, or letter 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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	1 - STATE REGISTRAR	STATE OF MARYLAND /		MENT OF H		D MEN	NTAL HYGIEN			
	Mary Marga	cet Johnso	m				DATE OF DEATH	3×19	YEAR.	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER 215-22-2062 9a. FACILITY NAME (# not institution, give s	5. SEX 6. AGE (In yrs. las	YRS.	IF UNDER 1 YEAR HONTHS DAYS	HOURS MI	". J	Month, Day, Year)	1913	Mar	yland
TOR	Harford Memoria			96. CITY, TOWN O				Har Har		
DIRECTOR		rford		rown on Location						10d. INSIDE CITY LIMITS? 1 XYES 2 NO
FUNERAL	659 Elm Street			101.	2100	1			U.S	AT COUNTRY?
ВУ	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER IN U.S. AR FORCES? 1 YES 2 XX IF YES, GIVE WAR OR DATES		If yea, spe	ENDENT OF HIS city Cuben, Me 2 XNO Se	xican, Pu	RIGIN? (Specify Yes eno Rican, etc.)	or No-	4. RACE - Black, Specify	American Indian, White, etc.
COMPLETED	15. DECEDENT'S EQU- (Specify only highest grade Elementary/Secondary (0-12)	completed) (Gi	CEOENT'S U ive kind of wo Do NOT use	SUAL OCCUPATION of done during most retired.)	N at of working		16b. KINO OF BUS	SINESS/INDUS	STRY	
BE CON	17. FATHER'S NAME (First, Mildole, Lest) Randolph Johnso	on			18. MOTHER'S	NAME (F	First, Middle, Melden Ordery	Sumame)	_	
TO B	194. INFORMANT'S NAME (Type/Print) Cleo V. Johnsor						Number, City or Tow , Aberd			21001
	20e. METHOD OF DISPOSITION 1 CX Burial 2 Cremation 3 Rem 4 Donation 5 Other (Specify)	oval from State cemetery, cree	MD OATE OF metory or othe LE Br	ove ce	metar	У	Whi	cation — cii teha		
	21. SIGNATURE OF FUNERAL SERVICE LIC	- 1		22. NAME AN Beard Havre	ãe G	race	e, Md	210		
ATION	23. PART I. Enter the diseases, or a shock, or heart failure. IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentisity list conditions, if any, leading to immediate cause. Enter UNDERLYING	E. DUE TO (OR AS A CONSECUE	ne 1	hear faile	t fo	TLC	cardiac or reapl	ratory srres	st,	Approximats interval Between Onset and Death
CERTIFICATION	CAUSE (Disesse or injury thet initiated events resulting in death) LAST	DUE TO FOR AS A COMSED	diguis	mal-	lun	10				
MEDICAL O	PART II. Other significant condition				_	in Part	1 YES 2	MEDT	0	WERE AUTOPSY PINDINGS NAILABLE PROOR TO DOMPLETION OF CAUSE OF DEATH?
PHYSICIAN:	DID TOBACCO USE CONTI 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	E OF DEATH	(Check only and)	UNCERT	AIN []			
BY PHYS	1 YES 2 NO 27. MANOSER OF DEATH 1 Netural 5 Pending Investigation	28a. DATE OF INJURY (Month, Dep. 16er)		OF ZBc. INJU	MY AT	-	Other (Specify) DESCRIBE HOW II	NJURY OCCUP	NED	
品	3 Suttible 6 Could not be defarmined	28s. PLACE OF MUURY — At hor mutiding, etc. (Specify)	ma, farm, atro	wel, factory, office		381.	LOCATION (Street a City or Town, State)	and Number or	Hural Hos	ulle Numbbe.
COMPLET		CIAN: To the best of my knowledge, dea R: On the basis of examination and/or in								and manner as stated.
TO BE C	296. SIGNATURE AND TITLE OF CERTIFIER	In MD			29c LICENSE	NUMBER 200	61.	POL DATE S	Of i	12/8 t
_	30. NAME AND AD THE BOTH WHO COLOR OF PERSON WHO	MD. 3075	27) (Type, P	1000 S	X170	Kla	ione de	ero	40	MD.
	31. DATE FILED MOTOR 24 199	13 June manager	WOOD IN							

` E . E

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAMBARGARITA KORELL M.D.

1995

32 REGISTRAR'S, SIGNATURE

31. DATE FILED (Month, Day, Year)

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

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	1 - STATE REGISTRAR	STATE OF M					EALTH AND DEATH	MENTA	AL HYGIEN REG. NO.	E			
	1. DECEDENT'S NAME (First, Middle, Last)		· · · · · · · · · · · · · · · · · · ·						E OF DEATH			3. TIME OF DE	ATN
	BERNADINE (nmn) JAKELI	CST					OC		, 19	YEAR	9:00	7\ M
	4. SOCIAL SECURITY NUMBER		6. AGE (In yrs. last	birthday)	IF UNDER	t YEAR	IF UNDER 24 HRS.	7. DATI	E OF BIRTN		a BURTH	IPLACE (State or	Foreign
	218-36-7370	1 □ M 2 💢 F	56	YRS.	MONTHS	DAYS	HOURS MIN.	Mar	ch 6,1	v -		yland	
OR	98. FACILITY NAME (If not institution, give st 3945 KENYON AVI						ORE C			9c. COL	INTY OF D	PEATH	
DIRECTOR	RESIDENCE OF DECEDENT 10a, STATE 10b, COUNTY			7.1 A.	Y. TOWN O		III.os						
<u> </u>				10c. CI1	.,							10d. INSIDE CI LIMITS?	
	Maryland 100. STREET AND NUMBER				Balt							1 X YES 2	-,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
RA						101.	. ZIP CODE			10g. CIT		WHAT COUNTRY	?
FUNERAL	3945 Kenyon Ave.						212				US	A	
	11. MARITAL STATUS 1 Never Married 2 Merried	12. WAS DECEDENT FORCES? 1 [IF YES, GIVE WI	YES 2XN	MED	- 10	yes, spe	ENDENT OF HISE ecify Cuban, Maxi 2 X NO Spe	Icen, Puerto		or No-	14. RACI Black Spec	E — American in k, While, etc. #y:	dlen,
ВУ	3 Wildowed 4 Divorced											Whit	e
	15. DECEDENT'S EDUC (Specify only highest grade	CATION completed)	(Gr	ve kind of	USUAL OC		ON st of working	16	b. KIND OF BU	SINESS/IN	DUSTRY		
Ш	Elementery/Secondary (0-12)	College (1-4 or 5+)	lilo	Do NOT u	se retired.)		or an arouning						
COMPLET	12		Se	cret	ary				State	Gov	ernm	ent	
Ö	17. FATNER'S NAME (First, Middle, Last)						16. MOTNER'S I	NAME (First,	, Middle, Malden	Surname)			
ш	Walter Stanley	Jakelski					Jessi	e	Pil	ot			
9 8	19a. INFORMANT'S NAME (Type/Print)		191	MAILING	ADDRESS	(Street a	nd Number or Run	al Route Nui	mber, City or Tow	n, State, Zi	ip Code)		
10	Theodore E. Jakel:	ski, Sr.	1	901	Hawth	norn	e Rd.,	Edge	wood, M	D 2	1040		
	20a. METNOD OF DISPOSITION 1 X Burlel 2 Cremation 3 Remo	oval from State	20b. PLACE A	metory or o	ther plece)			1			- City or To		
	4 Donation 5 Other (Specify)	ENCEC	Parkw	00d			D ADDRESS OF		-95 Ba	Itim	ore,	Md.	
	It al	1. M.	. l				d K. Mc		s III F	uner	al H	iome, P.	A.
	suply /	. yug	W				Cokesbu						
	23. PART I. Enter the diseases, or o	omplications wat	caused the de	ath. Do								Approxi	mate
	ahock, or heart fellure.	List only one ceus	se on each line										Between nd Daath
	disease or condition	. ATHER	105 00	V.et	1,0	50	00000	5 (111	An .	Disc	DSG		
	readiting in death)	DUE TO (OR AS A CONSEC	DUENCE O	F):	4	0 (00 (3	2000	310	VI	1-2	-	
z													
CERTIFICATION	Sequentielly list conditions, if any, leading to immediate	DUE TO (OR AS A CONSEC	UENCE O	F):	-							
S	cause. Enter UNDERLYING	C.											
E	CAUSE (Disease or injury that initieted eventa	DUE TO (OR AS A CONSEC	UENCE O	F):								
E	reaulting in deeth) LAST	d											
2	DART II Other significant appdition	n anni-ibil in	death had not a		1				T				
MEDICAL	PART II. Other algnificant condition	in contributing to	seath put not h	bealting	in the un-	derlying	g cause given	in Part I.	24a. WAS AN PERFOR		240	AWAILABLE PRIC	OT RO
ă									1 X YES 2	□ NO		OF DEATH?	F CAUSE
M							/		INSP	ECT:	ION	1 _ YES 2 _	NO
ä	DID TOBACCO USE CONTI	RIBUTE TO CA	JSE OF DEA	TH Y	ES 🗆 N	10 []	V UNCERTA	AIN 🗆					
CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLAC	E OF DEA	TN (Check o								
YSI	EXAMINER?	1 Inpetient 2 I	ER/Outpatient 3	□ DOA	4 Num	ing Hom	e 5XX Hesidenc	a 6 🗆 Ott	ner (Specify)				
PHYSICIAN:	27. MANNER OF DEATN 1 Netural 5 Pending	28e. DATE OF (Month, Da		26b. TIN	JURY		RK?	26d. D	ESCRIBE NOW I	NJURY O	CCURED		
ВУ	2 Accident Investigation				М		YES 2 NO						
	3 Suicide 6 Could not be 4 Homicide determined	28a. PLACE OF building,	FINJURY — At ho etc. (Specify)	me, ferm,	atreat, facto	ory, offici			CATION (Street by or Town, State)		er or Rural i	Route Number,	
E	DA. CERTIFIED												
1PL	29a. CERTIFIER (Check only												
COMPLETED	2 X MEDICAL EXAMINE	A: On the besis of ex	amination end/or i	rrvestigation	on, In my o	pinion, d	eath occured at t	the time, da	te and place, ar	id due to t	the cause(e) and manner as	stated.
BE C	200. NIGHATURE AND TITLE OF CENTRIES	1 .0			***************************************		29c. LICENSE N	UMBER		29d. DA	TE SIGNED	17, 19	25
00	Wall ato the	(NIV)					O.C.N	M.E		D O	CT.	17,19	95

M.D. 111 Penn Street, Baltimore, Maryland 21201

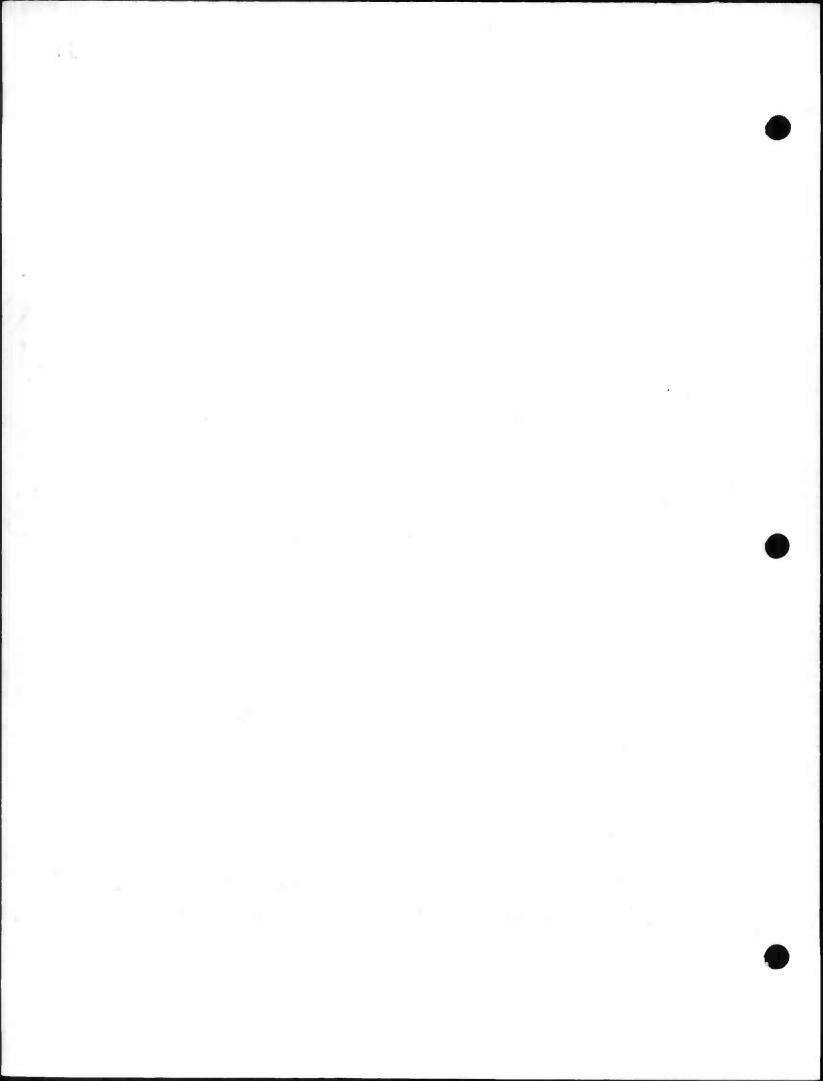
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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STATE OF MAR	RYLAND /	DEPARTMENT	OF I	HEALTH	AND	MENTAL	HYGIENE
	CE	ERTIFICATE	OF	DEAT	H		REG. NO.

	FOR STATE REGISTRAR	STATE OF MARYLA	AND / DEPAR CERTIF	TMENT	OF H	EALTH	AND M	IENTAL HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Last)							2. DATE OF DEATH			. TIME OF DEATH
	Miguel	Jaureguizar	Jr.					October 26	19	95	12:30Am
	4. SOCIAL SECURITY NUMBER		n yrs. last birthday)	IF UNDER	1 YEAR	IF UNDER	2001	7. DATE OF BIRTH (Month, Day, Year)		. BIRTHPL Country)	ACE (State or Foreign
	579-66-9229		73 YRS.					Sept. 4,		San	tiago,Cuba
m.	9a. FACILITY NAME (If not institution, give str						ON OF DEA	ATH	9c. COUNT		
5	102 Rosewood Drive	3		Gı	reen	belt			Prin	ce G	eorges
EC.	10a. STATE 10b. COUNTY		10c. CIT	Y, TOWN O	OR LOCAT	ION				1	0d. INSIDE CITY
0		ince Georges	G	reenb	oelt					1	YES 2 NO
₹	10e. STREET AND NUMBER				10f.	. ZIP CODE					AT COUNTRY?
FUNERAL DIRECTOR	102 Rosewood Dri				\bot		2077			ıba	
	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT EVER IN FORCES? 1 YES	2 XNO	- 1	If yes, spe	ecify Cuba	n, Maxican	C ORIGIN? (Specify Yas , Puerto Rican, atc.)	or No- 1	4. RACE - Black, 1	- American Indian, White, etc.
B	3 Widowed 4 Divorced	IF YES, GIVE WAR OR DA	TES	1	1 X YES	2 NO	Specify:	Cuban		Specify:	White
8	15. DECEDENT'S EDUC (Specify only highest grade of	ATION	16a. DECEDENT'S					16b. KIND OF BUS	SINESS/INDU	STRY	
<u> </u>	Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind of life. Do NOT u	se retired.)	during mus	St OF WORKE	ig				7.5
COMPLETED		4	Accor	untar	ıt			Bankin			
8	17. FATHER'S NAME (First, Middle, Last)	·	0			18. MOTH		NE (First, Middle, Maiden			
BE	Miguel J 190. INFORMANT'S NAME (Type/Print)	Jaureguizar,						nown Cur			
2	Estrella Juaregu	iizar						oute Number, City or Tow Greenbelt		2077	70
	20a. METHOD OF DISPOSITION	20b.	PLACE AND DATE				Lve,		CATION — CI		
	1 🖾 Buriel 2 🗆 Cremation 3 🗆 Remo	well from State		the endered			rv 1(0/30/95 S			
	21. SIGNATURE OF FUNERAL SERVICE LICE	ENSEE		22.	NAME AN	ID ADDRES	SS OF FAC	ILITY			
	I YED	tions		Fr	anci	is J.	. Col	lins Fune	ral Ho	ome,	Inc.
	23. PART I. Enter the diseases, or co	omplications that caused	the death. Do					Blvd.W.			20901 Approximata
		List only Dne cause Dn ea			-					,	Interval Batween Onset and Death
	disease or condition resulting in desth)	PCO S	toto		(0	100	0	λ			
	resulting in destri)	DUE TO (OR AS A	CONSEQUENCE O	F):		_, ,					
×	Sequentially list conditions,	x									
ATK	if sny, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A	CONSEQUENCE O	F):							
CERTIFICATION	CAUSE (Disease or injury that initiated events	DUE TO (OR AS A	CONSEQUENCE O	F):	-						
E	resulting in death) LAST	4									!
	DADT II Other eignificant condition	a contributing to death by	- net consisting	to the re	v m a		-toron In I				
MEDICAL	PART ii. Other significant conditions	g contributing to death be	It not resulting	In the un	ideriying) cause (jiven in r	Part I. 24a, WAS AN PERFOR		A	WAILABLE PRIOR TO
								1 YES 2	Xio	0	OMPLETION OF CAUSE OF DEATH?
	DID TOBACCO USE CONTR	PIRLITE TO CAUSE OF	F DF ATH Y	ES	NO F	1 LINC	ERTAIN	X		1	YES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEA			1 0140	EKIM	A	_		
SIC	EXAMINER?	HOSPITAL:	atlant 3 DOA	OTHER	R:	n 5 KRr	eldenca (8 Other (Specify)			
Ĭ	27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b, T/N		28c. INJI			28d. DESCRIBE HOW I	NJURY OCCU	RED	
ВУБ	Natural 5 Pending Accident Investigation	(Moran, Day, rear)		M		YES 2	_ NO				
ED E	3 Suicide 6 Could not be	26e. PLACE OF INJURY building, atc. (Speci	- At home, farm,	atreet, fact	lory, office			261. LOCATION (Street City or Town, State)	and Number o	r Rural Rou	ite Number,
	4 Homicide detarmined										
APL	one)	CIAN: To the beat of my knowle									
COMPL	2 MEDICAL EXAMINES	R: On the beals of examination	and/or investigation	on, in my o	opinion, d	eath occur	red at the t	time, data and placa, an	d due to the	cause(a) a	ind manner as stated.
BE (29b. SIGNATURE AND TITLE	21/1/1/1/1	MX			29c. LICE	ENSE NUMI	BER	29d, DATE	SIGNED (A	Aonth, Day, Year)
2	30. NAME AND ADDRESS OF PERSON WHO	W/V/V	111				30	164	1	1-6	6-7
	30. NAME AND ADDRESS OF PERSON WHO	2 110 COMPLETED CAUSE OF BEA	ITH (ITEM 27) (Type	Print)	61	200	A	OLLO	2	20	m
	31. DATE FILED (Month, Day, Year)	22. REGISTRAR'S SIGNA	ATMRE	JK.	, 01	acc	11	CITI	3 X)	4	
	OCT 2 7 1995 A	alla d'avideor Res	tall.								



examiner must be notified at once.	IMPORTANT: if Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
le.	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
he funeral director, page 5 should be detached	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached
r death. Page 6 may be retained by the hosp	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, Page 6 may be retained by the hosp

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND ME	NTAL HYGIENI
CERTIFICATE OF DEATH	REG. NO.

	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPAR	TMENT OF CATE OF	HEALTH AND		GIENE G. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)		O E I I I I I	OAIL OI	DEATH	2. DATE OF DE			3. TIME OF DEATN	
	Josep	ohine E.	Jackso	n .		Oct	DAY	995	2:35 P M	
1 1			In yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIF			IPLACE (State or Foreign	
	220-40-7232 1 9a. FACILITY NAME (If not institution, give stree	□ M 2 📯 F 76	YRS.	MONTHS DAYS	HOURS MIN.		0,1919	Ma	aryland	
OR	Shady Grove Adv		sp.		or Location of D	DEATH		nty of D	omery	
띱	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		10c. CITY	TOWN OR LOC	ATION				10d. INSIDE CITY	
DIRECTOR	Maryland Monto	gomery		ckvil					LIMITS?	
FUNERAL	10a. STREET AND NUMBER			1	Of. ZIP CODE		10g. CIT	IZEN OF Y	WHAT COUNTRY?	
띨	95 Dawson	Ave, Apt#	408		20850		U	.s.A	A .	
5		2. WAS DECEDENT EVER IN FORCES? 1 YES	U.S. ARMED	13. WAS DE	CENDENT OF NISPA	NIC ORIGIN? (Spe	city Yes or No-		E — American Indian, k, White, atc.	
BY	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE WAR OR DA	TES		S 2 NO Speci		etc.)		lack	
	15. DECEDENT'S EDUCAT	TION T	16a. DECEDENT'S	ICULA COCURAT	lan				Stack	
COMPLETED	(Specify only highest grade con	mpleted)	(Give kind of w	ork done during n	iost of working	166. KIND	OF BUSINESS/INC	DUSTRY		
⊒	7th Grade	College (1-4 or 5+)	House	wife		_ _ ,	None			
8	17. FATHER'S NAME (First, Middle, Last)		110036	MITE	16. MOTNER'S NA	AME (First, Middle,				
BE C	Henry J.	Campbell			The second second second		ewell			
		aughter)	19b. MAILING	ADDRESS (Street	and Number or Rural			Code)		
2	Mrs Helen Christ		1753	3 Ami	ty Dr,	Gaithe:	rsburg	. Mc	20877	
	20a, METHOD OF DISPOSITION 20b PLACE AND DATE OF DISPOSITION (Name of									
	1 State 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Brooke Grove Cemetery 10/25 Laytonsville, Md									
	25-SIGNATURE OF FUNERAL SERVICE LICEN	ACILITY								
	WIRE K.	Mour	der		vden Fu					
	23. PART i. Enter the diseases, or com-	nplications that coused	the death. Do n	ot enter the m	ode of dying, au	ch aa cardiec p	r reapiratory an	rest,	Approximate	
	ahock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Fine) Another than the state of the property of the state of the state of the property of the state of the stat									
- 1	disease or condition Ventricular Failure									
	DUE TO (OR AS A CONSEQUENCE OF):									
Z	Hyperkalemia 60 Min									
CERTIFICATION	If any, leading to immediate									
	CAUSE (Disease or injury	Possi	ble Myc	cardia	al Infa	rction			60 Min	
Ē	thet initiated eventa resulting in death) LAST	DOL TO (DIT AS A	CONSECUENCE OF).						
S	d									
AL.	PART il. Other aignificant conditions c					Part i. 24a. V	MAS AN AUTOPSY PERFORMED?	24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO	
8		ge Renal			etes,	1	YES 2 NO		COMPLETION OF CAUSE OF DEATH?	
ME		c Cardiom					4.5		1 - YES 2 - NO	
ä	DID TOBACCO USE CONTRIB					N 🗆				
PHYSICIAN: MEDIC		IOSPITAL:	26. PLACE OF DEAT	(Check only one OTHER:						
ΥS	YES 2 NO 1	Inpetient 2 X ER/Outpe	Hient 3 DOA	4 - Nursing Ho	ne 5 🗆 Rasidenca					
	1 Natural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME	RY W	JURY AT ORK?	28d. DESCRIBE	NOW INJURY OC	CURED		
B	2 Accident Investigation	28e. PLACE OF INJURY	At home form of		YES 2 NO		-			
	3 Suicide 6 Could not be 4 Nomicide determined	building, etc. (Speci	fy)	reet, factory, one		City or Town	(Street and Number i, State)	or Rural F	loute Number,	
91	29a. CERTIFIER					5.11.25 p. 11.25 p. 11.25	-			
COMPLETED	(Check only one) 1 CERTIFYING PNYSICIAL (Check only one) 2 MEDICAL EXAMINER: C) and menner as stated.	
BE C	396. SIGNATURE AND TITLE OF CONTIFIER			29c. LICENSE NU				(Month, Day, Year)		
5	Jayma	1			D-2134	40	▶ C)ct	20, 1995	
	30. NAME AND ADDRESS OF PURSON WHO CO				, Wheat	ton Mo	20906	5		
	24 DATE EN ED (Marth Day Mart	I and the second			,					
	OCT 23 1995	ulia Davidson	tardall							
									DHMH-16 Rev 1/89	

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or atte	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use a	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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	FOR								9	0 3	13693
	1 - STATE REGISTRAR	STATE OF MAR	RYLAND / DI Cer	EPARTI	MENT OF H CATE OF	EALTH A	ND MEN.	TAL HYGIEN REG. NO			
	1. DECEDENT'S NAME (First, Middle, Last)						2.0	TE OF DEATH			3. TIME OF DEATH
		Marie Ke					OC.	tober	25,1	995	5:30P.M
	4. SOCIAL SECURITY NUMBER	5. SEX 6. /	AGE (In yrs. lest birthday) IF UNDER t YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			RS. 7. DA	TE OF BIRTH	1	8. BIRTHP	LACE (State or Foreign	
	175-26-2130	62	YRS.				v. 7,1	1932	Pen	nsylvania	
DIRECTOR	810 Franklin					inste			9c. COU	arro.	ath 11
딥	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT	TY	T is	IOC CITY T	TOWN OR LOCAT	ION					10d. INSIDE CITY
PIR	Maryland Car	roll			stmins						LIMITS?
	10e. STREET AND NUMBER				101.	ZIP CODE			10g. CITI		AT COUNTRY?
ER	810 Franklin	Ave				2115	57			J.S.	
FUNERAL	11. MARITAL STATUS 1 Never Married 2 Merried	12. WAS DECEDENT EV	YES 2 NO	D	13. WAS DECI	ENDENT OF H	ISPANIC ORI	GIN? (Specify Yes	or No-	14. RACE - Black,	- American Indian, White, atc.
ВУ	3 XWidowed 4 Divorced	IF YES, GIVE WAR O	OR DATES			2 XNO 8					White
밀	15. DECEDENT'S EDI (Specify only highest grad		16a. DECEO	DENT'S US	UAL OCCUPATIO	IN st of working		16b, KIND OF BU	SINESS/INC	USTRY	
COMPLET	Elementary/Secondary (0-12)	College (1-4 or 5+)	life, Do	NOT use re	etired.)	•		a : .			
N	17. FATHER'S NAME (First, Middle, Last)			OWI	ner			Statio			
BE C	Andrew P. Gav	in				Mary		st, Middle, Maiden	Sumeme)		
0 8	19a, INFORMANT'S NAME (Typer/Print) 19b. MAILING ADDRESS (Street and Number or Bural Route Number, City or Town, State, Zio Code)								21102		
١٤	John M. Kelly III 3100 Southwestern Ave, Manchester, Md.										
	20e. METHOD OF DISPOSITION 1 Surial 2 Cremetion 3 Ren 4 Donation 5 Other (Specify)		20b. PLACE AND cometery, cremato	nev or other	placel		1			City or Tow	
	21. SIGNATURE OF FUNERAL SERVICE L		St. Jo	onn's	22. NAME AN	OADDRESS	T U	728 WE	stm	nste	er, Md.
	Nancyt 7	Water J			254 E	. Mai	n St	reet,	West	min	ster, Md.
										Approximata	
	IMMEDIATE CAUSE (Final Assets)									Interval Batween Onset and Death	
	disease or condition resulting in death) a. CARCINOMA The Cancreas								1gr,		
1	DUE TO (OR AS A CONSEQUENCE OF):										
NO.	Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF):										
SAT	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury c.										
E	that initiated events resulting in death) LAST	DUE TO (OR	AS A CONSEQUE	NCE OF):							
CERTIFICATION	resulting in death) CAST	d									
	PART II. Other significent condition	ns contributing to desi	th but not rasu	iting in t	ha underlying	cause give	n in Part i.			24b. ¥	VERE AUTOPSY FINDINGS
MEDICAL								t YES 2			MAILABLE PRIOR TO COMPLETION OF CAUSE
ME											F DEATH?
	DID TOBACCO USE CONT	RIBUTE TO CAUSE				UNCER	TAIN 🗆				
SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		0	Check only one) THER:						
PHYS	1 YES 2 NO 27. MANNER OF CEATH	1 Inpatient 2 ER/		DOA 4	Nursing Home						
	1 Natural 5 Pending	(Month, Day, Ye.	er)	INJURY	WOF			EŞCRIBE HOW II	NJURY OCC	URED	
D BY	2 Accident Investigation 3 Suicide S Could not be	28e. PLACE OF INJ building, etc. (URY — At home, i	lerm, stree			281. L	OCATION (Street e	nd Number	or Rural Rou	ite Number,
ETE	4 Homicide determined							ny or rown, state)			
APL		ICIAN: To the best of my lo									
COMPL	2 MEDICAL EXAMIN	ER: On the basis of examin	ation and/or inves	stigation, ir	n my opinion, de	ath occured a	t the time, d	ate end place, en	d due to the	cause(e)	and manner se stated.
BE (296 SIGNATURE AND TITLE OF CERTIPLE	15/1/	. 111	10		29c. LICENSE		700	29d. DATE		forth, Day, Year)
0 30, WARRE AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Item Cont.)									27-95		

LETEO CAUSE OF DEATH (ITEM 27) (Type, Print)

DEAN H. GRIFFIN,

31. DATE FILEO (MONTE). Cap: Year].

OC 1 2 7 1995

1995

M.D. 19 RIDGE RD.,
32. REGISTRAR'S SIGNATURE
Julia Dhucker Rawlell

WESTMINSTER, MD.

21157

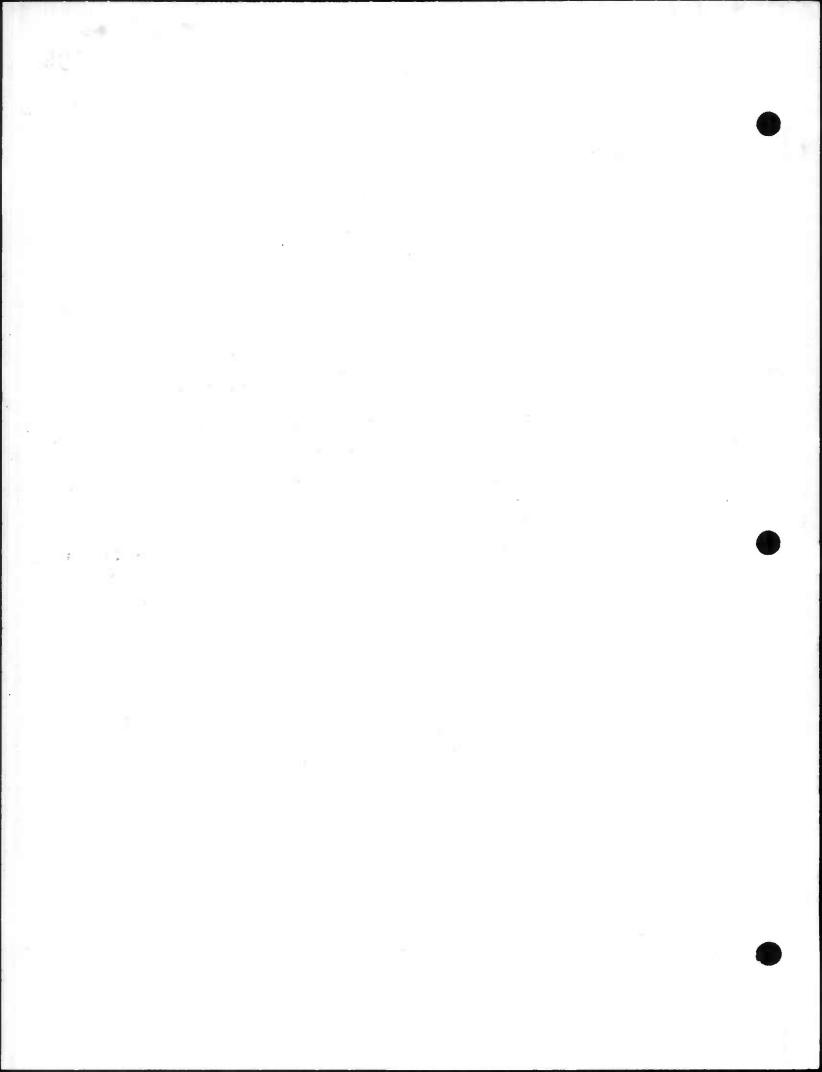
DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within—a hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPARTM CERTIFIC	IENT OF HEALTH AND ATE OF DEATH	MENTAL HYGIENE REG. NO.					
15	DECEDENT'S NAME (First, Middle, Last)	Joseph Jacob	Kaiser,	Jr.	2. DATE OF DEATH MONTH DAY	7 1995 4:45 M				
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE	(In yrs. last birthday) IF	UNDER 1 YEAR IF UNDER 24 HRS.	7. DATE OF BIRTH 19	31 BIRTHPLACE Islate or Foreign Country) District				
	579-42-6917 Se. FACILITY NAME (If not institution, give at	1 M 2 F	64 YRS.	CITY, TOWN OR LOCATION OF C	January 31,	of Columbia				
DIRECTOR	Washington Count			Hagerstown	ZAIN	Washington				
REC	10a. STATE 10b. COUNTY			OWN OR LOCATION		10d. INSIDE CITY				
	Maryland Frede	rick	Emmi	tsburg		1 Ø YES 2 □ NO				
FUNERAL	103 West Main S.	thoot		101. ZIP CODE 21727	10	U.S.A.				
5	11. MARITAL STATUS	12. WAS DECEDENT EVER II FORCES? 1 YES	N U.S. ARMED	13. WAS DECENDENT OF NISPA	NIC ORIGIN? (Specify Yes or I					
BY	1 Never Married 2 Married 3 Wildowed 4 Divorced	IF YES, GIVE WAR OR D		If yes, specify Cuben, Maxic 1 TYES 2 X NO Speci		Specify: White				
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade	ATION completed)	16e. DECEDENT'S USU	IAL OCCUPATION	18b. KIND OF BUSINE					
	Elementary/Secondary (0-12)	College (1-4 or 5+)		done during most of working ired.)	Austinua					
WO	17. FATNER'S NAME (First, Middle, Lest)		Dealer	16. MOTHER'S N	Antique Ame (First, Middle, Meiden Surn					
BEC	Joseph J. Kaiser	Sr.			e H. Wagoner					
2	19e. INFORMANT'S NAME (Type/Print)			DRESS (Street and Number or Rural						
	Harold C. Craig.			t Main St. Emm		21727				
	20b. PLACE AND DATE OF DISPOSITION 1 Densition 6 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of Committee) 20b. PLACE AND DATE OF DISPOSITION (Name of Committee) 20c. LOCATION — City or Town, State 20c. LOCATION — City or Town, State 20c. LOCATION — City or Town, State 20c. LOCATION — City or Town, State 20c. LOCATION — City or Town, State									
	21. SIGNATURE OF JUNERAL SERVICE LIC		MATIS DUNCY	22 NAME AND ADDDESS OF E	ACII ITW					
	1 /auclas	A Luin	//	Davis Funera	l Home Smith	Bradbury Ave. sburg, Md. 21783				
	23. PART V Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or Heart fellure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. C. ERBBRO MECHANIC ALLIST LEFT HEITS PITTIME. DUE TO (OR AS A CONSEQUENCE OF):									
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST B. ATUER SCUENDL CAMBIU- WROUMN DISEAS. Character of the cause of the									
PHYSICIAN: MEDICAL	PART II. Other algorificent conditions FW) (McE RRW	4 DIS. ;	PERIPHRANC	MEC. DIS.	Part I. 24a. WAS AN AUTI PERFORMED 1 - YES 2	0? AMILABLE PRIOR TO				
AN	DID TOBACCO USE CONTR		PEATH YES		NB					
SICI	EXAMINER?	HOSPITAL:	01	HER: Nursing Home 5 Residence	2 - Other (One-14)					
	27. MANNER OF DEATH 1 Partial 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF		28d. DESCRIBE NOW INJUR	RY OCCURED				
TED BY	2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJURY building, atc. (Spec	— At home, farm, stree		28f. LOCATION (Street and N City or Town, State)	Number or Rural Route Number,				
COMPLETED				the time, date and place, and during opinion, death occured at the		as stated,				
TO BE C	296. SIGNATURE AND TITLE OF CERTIFIER	MO		29c. LICENSE NU	20150	d. DATE SIONED (Month, Day, Year)				
-	30. NAME AND ADDRESS OF PERSON WHO	ho 124	13 OHK 41	under ItACRASA	na 40 217	742				
	OCT 1 91995	2. REJISTRA SIG	ATURE							

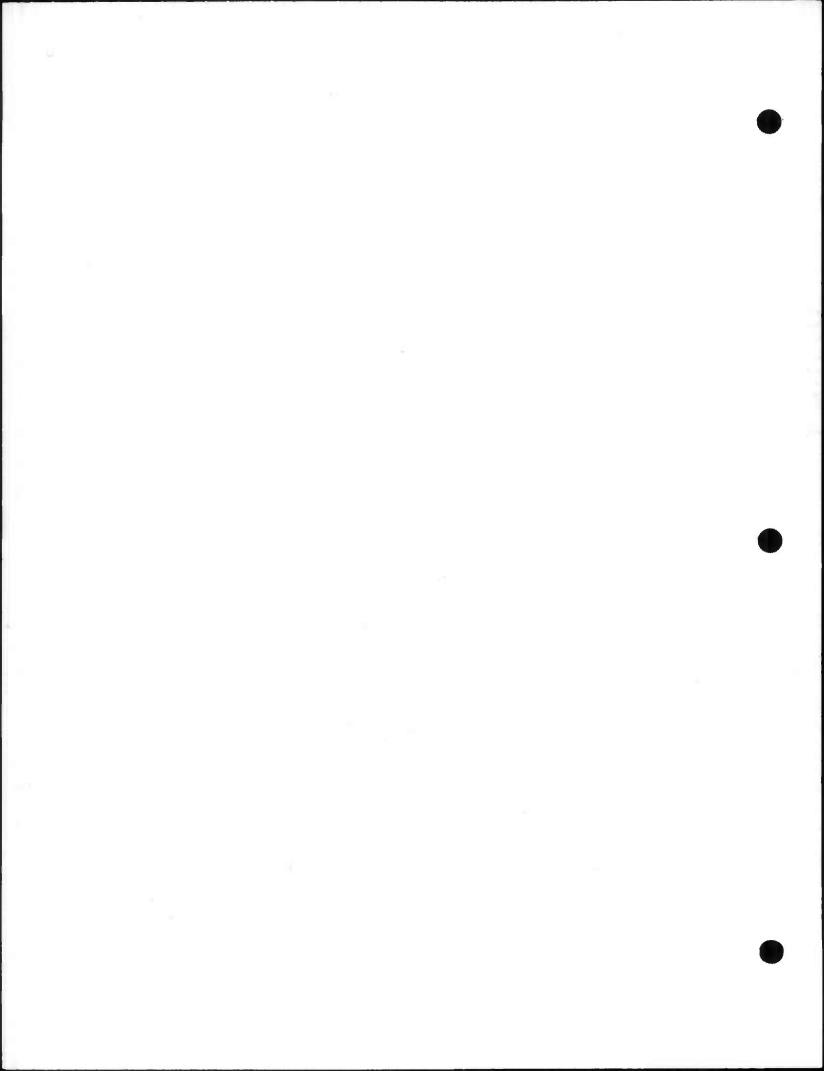


requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. See it is a standing physician. BALTIMORE, MARYLAND 21215-0020

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	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours	TO THE FUNERAL DIRECTOR: After this certificate has been stoned by the attending obvision and completely filled in
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1 - STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

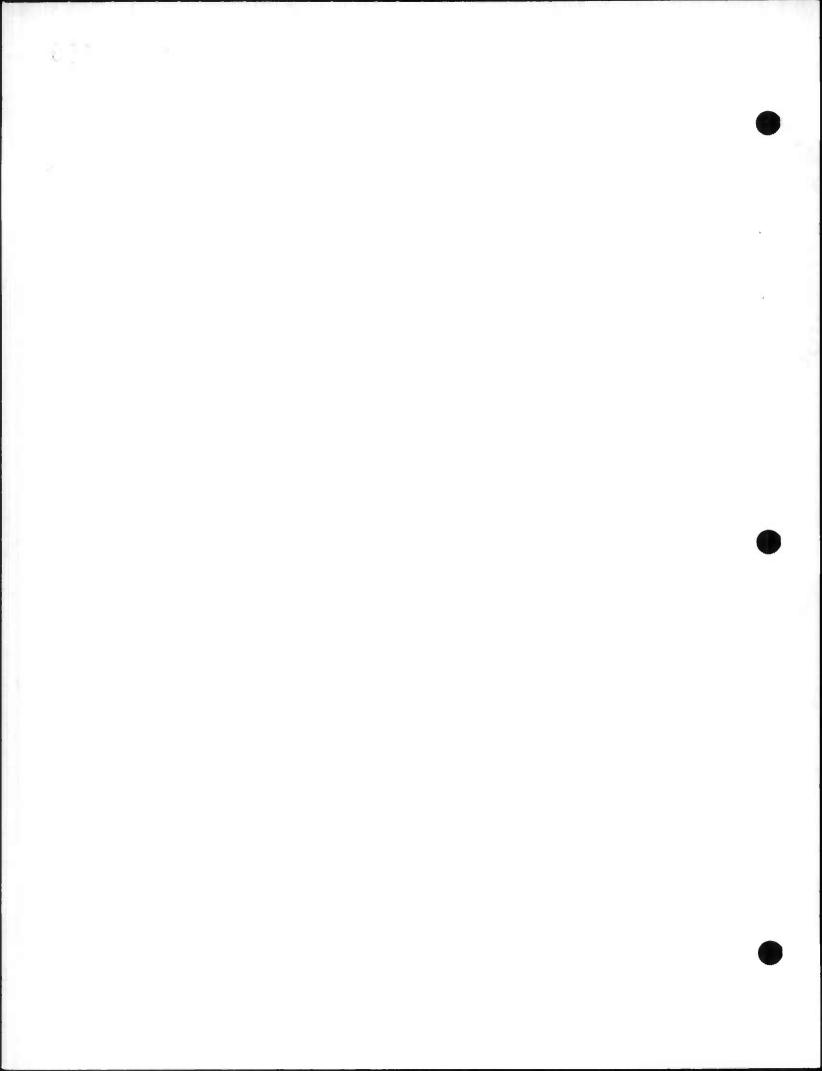
	1. DECEDENT'S NAME (First,	Middle, Last)							2. DATE O		MY	YEAR	3. TIME OF DEATH
	Medelia							Octo	ber 1		995	10:20 P M	
	4. SOCIAL SECURITY NUMBER	765	5. SEX	8. AGE (In yr	s. lest birthday)	IF UNDE	DAYS	IF UNDER 24 HRS.	7. DATE O	F BIRTH Day, Year)		6. BIRTH Countr	PLACE (State or Foreign
	218-62-5834		1 M 2 🔏 F	88	YRS.				Apr.	1, 1	907		st Virginia
	9a. FACILITY NAME (If not inatifution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH										EATH		
DIRECTOR	Memorial Hospital Cumberland Allegany												
జ		10b. COUNTY	_		10c. CIT		OR LOCA						10d. INSIDE CITY LIMITS?
	WV 104. STREET AND NUMBER		Preston			İ						1 YES 2 NO	
FUNERAL	Rt. 2, Box					10	2676	60		10g. CIT		VHAT COUNTRY? USA	
N N	11. MARITAL STATUS		12. WAS DECEOENT	EVER IN U.S	ARMED	13.	WAS DEC	ENDENT OF HISPAI		(Specify Ye	s or No—	14. RACE	- American Indian.
BY F	l l							ecify Cuban, Maxica 2 NO Specif	an, Puerto Ric	cen, etc.)		Black Speci	, White, atc.
	**	a X wromed a Divorced								White			
Ë	(Specify only	15. DECEDENT'S EDUCATION (Specify only highest grade completed) [Secondary (M.13)] [ON ast of working	16b. I	CIND OF BU	SINESS/INC	DUSTRY	
once. COMPLETED	Elementary/Secondary (0-1	12)	College (1-4 or 5 +)		usev				н	ome		
once.	17. FATHER'S NAME (First, Mid	idle, Last)			110	abev	1110	18. MOTHER'S NA	AME (First, Mil				
76	Thomas Park							Myrt:				Se	11
TO BE	19a. INFORMANT'S NAME (Typ.	oe/Print)			19b. MAILING	ADDRES	S (Street a	and Number or Rural	Route Number	r, City or Tow	rn, State, Zic	Code)	
De no		Thomas D. Kight P.O. Box 525, Oakland, Maryland 21550											
	20a, METHOD OF DISPOSITION 1	cemetery	CE AND DATE	ther place.)		OATE		CATION —				
E	4 Donation 5 Other (Specify) Red House Cem						emet		10/2	2 0 0	aklar	id, M	D
examiner must	▶ Q.M) A	To 1					o ADORESS OF FA		ame.			
-	1 3000	len H-	Medad				32 S	. Second	St.,	0akl	and,	MD	21550
medical	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert feliure. List only one cause on each line.										Approximate Interval Between		
2	IMMEDIATE CAUSE (Fine disease or condition	el.	T 1000	1	2.3		,						Onset and Death
E .	Intracerebral Hemorrhage Due to (or as a consequence of):								26 Days				
2										Unknown			
io mat	Sequentially list conditions, If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):												
E E	csuse. Enter UNDERLYING												
the I	CAUSE (Disease or injury that initiated events OUE TO (OR AS A CONSEQUENCE OF):												
ry, or other traumatic	resulting in death) LAST d												
700	PART II. Other significen	PART II. Other significent conditions contributing to deeth but not recuiting in the underlying ceuse given in Part I. 24s. WAS AN AUTOPSY FINDINGS											
es any Inju										PERFOI			AVAILABLE PRIOR TO COMPLETION DF CAUSE
MEC									_		65 110		OF DEATH?
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item 28 is marked, or item 23 PLETED BY PHYSICIAN	25. WAS CASE REFERRED TO EXAMINER?	MEDICAL	HOSPITAL:	26. P	LACE OF DEA	OTHE							
or I	1 YES 2 NO	1	1) Inpatient 2		-	4 🗆 Nu	rsing Hom	e 5 🗌 Residence		-			
marked, or BY PHY	1 Netural 5 P	ending	28e. DATE OF I (Month, Da		28b. TIM	E OF URY M		RK?	26d. DEŞCI	RIBE HOW I	NJURY OC	CURED	
mar BY	P. C. Sudaldia	vestigation	28e. PLACE OF	INJURY - A	t home form			ES 2 NO	261 1 001	ION (Dr			
28 is TED		ould not be Harmined	building, e	tc. (Specify)	· rome, rathe,	KI WUL, INC	iory, ornic		City or	Town, State)	ing Number	or Hurel H	oute Number,
item 2	29a. CERTIFIER 1 CERTIE	VING PHYSIC	TAN: To the heat of	ni kasulada	do eth comme	4 11							
			CIAN: To the beat of a										and manner as stated.
C	29b. SIGNATURE AND TITLE O							29c. LICENSE NUM					(Month, Day, Year)
IMPORTANT: 1	Lh	eden	A3	hko	~	177	フー	D 264					r 24th1995
일	30. NAME AND AGORESS OF	PERSON WHO	COMPLETED CAUSE	E OF DEATH	ITEM 27) (Type,	Print)		2 204				LODE	T - [101333
	Dr. Kheder A		, Johnson	n Heig	hts Me	dica	al B	ldg., C	umber:	land,	MD	2150	2
	31. DATE FILEO (Month, Day, Ye OCT 2 7	7 1995	32. REGISTRAR	S SIGNATUR	18								
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	TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or atter	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.	
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH 3. TIME OF DEATH										3. TIME OF DEATH		
	Kenneth	Dale	KITZ	ZMILLER						10 23 1995 9:20			9:20 a m
	4. SOCIAL SECURITY NUMI	SER	5. SEX	5. SEX 6. AGE (In yrs. Ia			EAR			7. DATE OF BIRTH		8. BIRTHPLACE (State or Foreign	
	236-68-2502	2	1 🔀 M 2 🗆 F	IX M 2 □ F 53 YRS. MONTHS D				HOURS	MIN.	Nov.13, 1941			yland
	Se. FACILITY NAME (If not in	estitution, give s	treet and number)			9b. CITY, TO	OWN O	R LOCATI	ON OF DE			UNTY OF D	
l R	Garrett County Memorial Hospital				1	l c	Oakland Garrett					-+	
DIRECTOR	RESIDENCE OF DEC	10b. COUNT	ν		I son CIT	Y, TOWN OR	OCATI	011					
1 5	wv		Grant					ON					10d. INSIDE CITY LIMITS?
	10s. STREET AND NUMBER		Grant		M	t. Sto	-	ZIP COD	F		100 0	TIZEN OF I	1 YES 2 X NO
FUNERAL	P.O. Box 11								- 26739	n	log. C		WHAT COUNTRY?
3	11. MARITAL STATUS		12. WAS DECEDEN	T EVER IN U.S. /	ARMED	13. WA	DECE	NDENT C	F HISPAN	VIC ORIGIN? (Specif	Ves or No-	USA La Baci	E — American Indian.
BY F	1 Never Married 2 X		FORCES? 1	YES 2 T	₹NO	lf y	н, вре	cify Cubs	n, Mexica Specify	n, Puerto Ricen, etc)	Spec	k, White, etc.
			<u> </u>									400	White
COMPLETED	(Specify only	EDENT'S EDU y highest grade	CATION completed)		'Give kind of a	USUAL OCCI	PATION ng mos	N t of workin	ng	16b. KIND OF	BUSINESS/II	OUSTRY	
1 2	Elementary/Secondary (0	1-12)	College (1-4 or 5	+)	le. Do NOT u			0					
\	17. FATHER'S NAME (First, M	Vicidia (nat)		l ue	eavy i	Equipm	ent		Account to the second	ME (First, Middle, Me	Mini		
		liver	Kitz	miller				Lec		ME (FIRST, MIDDIO, MA Mild:			
BE	19a. INFORMANT'S NAME (1		MILLZ		19b. MAILING	ADDRESS (S	traet en			POUTS Number, City or		Lar	rue
2	Anna M. Kit		er							rm, West			26720
	20a. METHOD OF DISPOSIT	ION		20b. PLAC	FANDOATE	OF DISPOSITI	M (Nan	no of		DATE 200			
	1 ☑ Buriel 2 ☐ Crematic 4 ☐ Donation 5 ☐ Other		oval from State	cemetery, c	Storn	ther plece) n Ceme	ter	v		10/26 N			
	21. SIGNATURE OF FUNERA	L SERVICE LIC	ENSEE			22. NA	WE AND	DADDRE	SS OF FA	CILITY		OIIII,	WV
	>						tew	art	Fune	eral Home I St., Oa	lel and	MD	21550
	23. PART I. Enter the d	seesea, or o	complications the	t caused the o	teeth. Do r								
	snock, or n	eart feilure.	List only one cau	ise on each lir	10.			0. 47.	rig, auci	il aa caldiec of fi	apiretory a	rreat,	Approximata Interval Between
	iMMEDIATE CAUSE (Fir disease or condition resulting in death)		Tasham	ia Uas	ant T	1:000							Onset and Death
1 4	resulting in death) a. Ischemic Heart Disease Due to (or as a consequence or): 4 days									4 days			
Z	Arteriosclerotic Cardio-Vascular Diseasee Unknown												
5	Sequentially list conditi if any, leading to imme-	diate	OUE TO	(OR AS A CONS	EQUENCE OF	F):							
CERTIFICATION	cause. Enter UNDERLYi CAUSE (Disease or inju		c										
E	that initiated events resulting in death) LAS	т .	DUE TO	(OR AS A CONS	EOUENCE OI	F):							
览			d										
	PART ii. Other algnifica	nt condition	a contributing to	death but not	reaulting	in the unde	rlying	cause g	lven in	Part I. 24s. WAS	AN AUTOPS	24b.	WERE AUTOPSY FINDINGS
MEDICAL											FORMED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE
WE											X		OF DEATH?
ä	DID TOBACCO U	SE CONTI	RIBUTE TO CA	USE OF DE	ATH YE	S I NO	<u>K</u>	UNC	ERTAIN	1 🗆			
PHYSICIAN	25. WAS CASE REFERRED TO EXAMINER?	MEDICAL	HOSPITAL:	26. PL/	CE OF DEAT	H (Check only	one)						
YSI	1 TYES 2 NO		1 Inpetient 2 X	XR/Outpatient	3 🗆 DOA	OTHER: 4 - Nursing	Home	5 🗆 Re	sidence	8 Other (Specify)			
표	27. MANNER OF DEATH 1 Netural 5	Pending	28a. DATE OF (Month, D		28b. TIM INJ	E OF 28 URY	: INJU WOR			28d. DESCRIBE HO	W INJURY O	CCURED	
B	2 Accident	restigation						ES 2 [NO				
유		Could not be	28s. PLACE O building,	F INJURY — At h etc. (Specify)	iome, farm, s	treet, factory,	office			28f. LOCATION (Str City or Town, S	et and Numb	er or Rural F	loute Number,
COMPLETED	AA 05 TE TO TO TO TO TO TO TO TO TO TO TO TO TO												
I de			CIAN: To the best of										
8				ramination and/or	Investigatio	n, in my opin	on, des	eth occur	ed at the	time, dete and place	and due to	the cause(s) and manner as stated.
BE	296. SIGNATURE AND TITLE	OF CENTIFIER	1	. /4		30	T	29c. LICE	NSE NUM	IBER	29d. DA	TE SIGNED	(Month, Day, Year)
10	Martin	19,	do	ohla	ug/h	200		D	0565	58	0	ctobe	r 23, 1995
	39. NAME AND ADDRESS OF												
	Herbert H. Leighton, M.D., 502 E. Oak Street, Oakland, Maryland 21550												
1	Herbert H.	Leigi	nton, M.I	502	E. Oa	ak Str	eet	, Oa	aklaı	nd, Mary	and	21550	
	31. DATE FILED (Month, Day,	Year)	32. DEGISTRA	n's signature	E. 0a	ak Str	eet	:, Oa	akla	nd, Mary	and	21550)

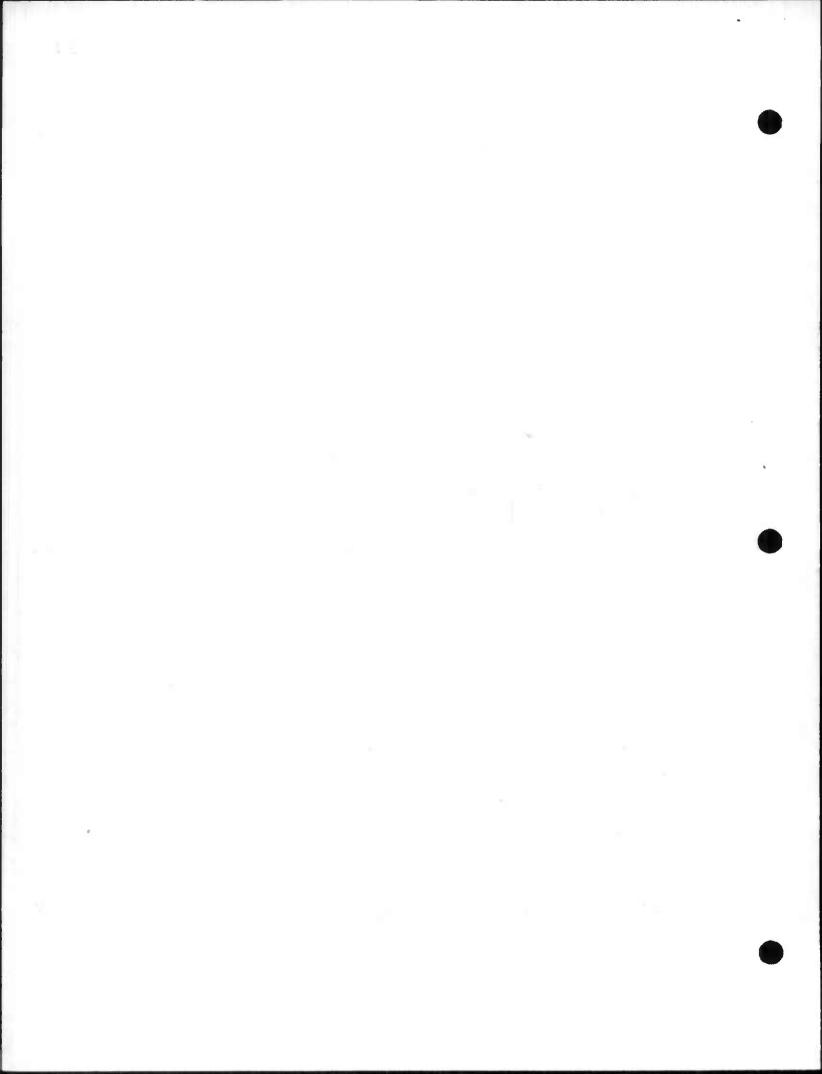


BALTIMORE, MARYLAND 21215-0020

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TO THE MODIFIED BY PAYSULANT IN 8 SAVIET BY REQUISES that the Geam certificate be executed within 12 hours after death. Page 5 though by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. or Health Hygiene prior to burial, cremation, or removal. **IMADIFIANT** If I ham 28 is marked, or the 24 should see the purpose and intuity or other permitted in a marked.

	FOR 1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPAI CERTIF	RTMENT OF H	IEALTH AND I	MENTAL HYGIEN			
	1. DECEDENT'S NAME (First, Middle, La	nat)				2. DATE OF DEATH		3. TIME OF DEATH	
	JAMES	F	KM	rem		October	17 19	95 10:45 DH	
1	4. SOCIAL SECURITY NUMBER 406-48-5445		(In yrs. last birthday)	1	IF UNDER 24 HRS.	7. DATE OF BIRTH	1.0	BIRTHPLACE (State or Foreign Country)	
1 3			5 YRS.	MONTHS DAYS	HOURS MIN.	oct. 30,	1939	Kentucky	
000	9e. FACILITY NAME (If not institution, gl				OR LOCATION OF DE	ATN	9c. COUNTY	OF DEATH	
DIRECTOR	Shady Grove Adve		Home	Rockvi	lle		Monte	gomery	
E C	10e. STATE 10b. COU		10c. CI1	TY, TOWN OR LOCAT	ION			10d, INSIDE CITY	
1 2	Texas Bexa	ar	S	an Anton	io			LIMITS?	
AL	10e. STREET AND NUMBER			101	. ZIP CODE		10g. CITIZEN	OF WHAT COUNTRY?	
FUNERAL	14650 Nacogdoche	es Road			78247		USA		
15	11. MARITAL STATUS	12. WAS DECEDENT EVER I FORCES? 1 YES	N U.S. ARMED	13. WAS DEC	ENDENT OF HISPAN	IIC ORIGIN? (Specify Yer n, Puerto Rican, etc.)	s or No- 14.	RACE — American Indian, Black, White, etc.	
BY	1 Never Married 2 Merried 3 Wildowed 4 Divorced	IF YES, GIVE WAR OR D			2 NO Specify			Snecify:	
	15. DECEDENT'S E	FOLICATION	16. DECEDENT'S	USUAL OCCUPATION		1		white	
	(Specify only highest gr Elementary/Secondary (0-12)	rade completed)		work done during mo		16b. KIND OF BU	SINESS/INDUST	RY	
□	Elementary/decordary (0-12)	3 years	Salesm	nan		Automo	tive	100-100	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				18. MOTNER'S NA	ME (First, Middle, Melden	Surneme)		
BE 0	Frederick Joseph	n Karem			Mary J	ane Mansfi	eld		
2	19e. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street e	nd Number or Rural F	Route Number, City or Tow	n, State, Zip Cod	(a)	
-	Brian Karem		16811	. Bethayr	es Road	Rockville	Mary.	land 20855	
	20a. METHOD OF DISPOSITION 1 ☐ Burlel 2 ☐ Cremetion 3XXA			OF DISPOSITION (Na	me of	1	CATION — City	7.5 E 17.5 E	
	4 ☐ Donation 5 ☐ Other (Specify)		netery, cremetory or calvary C				uisvil.	le, Kentucky	
	21. SIGNATURE OF POWERAL SERVICE	LICENSEE			dson Fun	eral Home	P.A.		
	(Trange)	, Kal	_	313 T	albott A	venue Lau	rel, Mo	d. 20707	
	23. PART I. Enter the diseases, o shock, or heart fallu	or complications that cause re. List only one cause on a	d the death. Do	not anter the mo-	da of dying, auci	h ss cardiac or reapi	iratory srrest,	Approximate	
	IMMEDIATE CAUSE (Finsi	10 1	CONTRACTOR OF THE PARTY OF THE	1		1		interval Between Onset and Death	
	disease or condition resulting in death) a. Metastate hung Carear - Small Cell more								
	DUE TO (OR AS A CONSEQUENCE OF):								
NO NO	Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF):								
AT	if any, leading to immediate cause. Enter UNDERLYING			. ,.					
Ĕ	CAUSE (Disease or injury that initiated events	DUE TO (OR AS A	CONSEQUENCE O	F):					
CERTIFICATION	resulting in death) LAST	d							
AL C	PART II. Other algnificant condit	iona contributing to death b	out not resulting	in the undertying	cause olven in	Part I. 24a. WAS AN	Airmney	24b. WERE AUTOPSY FINDINGS	
					, occor given in	PERFOR	MED?	AMAILABLE PRIOR TO COMPLETION OF CAUSE	
9						t □ YES 2	NO NO	OF DEATN?	
2	DID TOBACCO USE CON	NTRIBUTE TO CAUSE C	OF DEATH YI	ES 🗆 NO 🗆	UNCERTAIN	<u> </u>		1 TES 2 NO	
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF OEA		ONOLINIA	, ,			
SIC	1 YES 2 KNO	HOSPITAL; 1 ☐ Inpatient 2 ☐ ER/Out	patient 3 DOA	OTHER: 4 Nursing Nome	5 Residence	8 Other (Specify)			
E	27. MANNER OF DEATN	28e. DATE OF INJURY (Month, Day, Year)	28b. TIM	IE OF 28c. INJURY	JRY AT	28d. DESCRIBE HOW I	NJURY OCCURE	D	
ВУ	1 Natural 5 Pending 2 Accident Investigation	n		M 1 7	ES 2 NO				
	3 Suicide 6 Could not 1		- At home, ferm,	street, factory, office		261. LOCATION (Street of City or Town, State)	and Number or Ru	ural Route Number,	
COMPLETED									
AP.	29e. CERTIFIER (Check only one)	YSICIAN: To the best of my know	ledge, death occurr	ed at the time, date	end place, end due	to the cause(s) end man	ner es stated.		
8	2 MEDICAL EXAM	INER: On the basis of examination	n end/or investigatio	on, in my opinion, de	eath occured at the t	time, date and place, en	d due to the cau	use(s) and menner as stated,	
BE	29b. SIGNATURE AND TITLE OF CERTIF	ER	~~		29c. LICENSE NUM	. 1		NED (Month, Day, Year)	
0	30. NAME AND ADDRESS OF PERSON	WHO COMPLETED SHIPE ST	/ 43		71201	16	Poul	As 18, 1995	
	STEPHE] NE	IMA 1926	ATN (ITEM 27) (Type		1111	an Gant	4-1	20879	
	31. DATE FILED (Month, Day, Year)	32 REGISTBAR'S SIGN	1	7	or Hade 1	Ave. Gart	- s bu	ng Vra	
	OCT 2 3 199	5 Julia Diwalso	rhardall					,	
-		- 1/							



DIVISION OF VITAL RECORDS, P.O. BOX 68760 TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law TO THE FUNERAL DIRECTOR: After this certificate has be filed within 72 hours after death with the State Dept. IMPORTANT: If Item 28 is marked, or item 23:

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	been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 shour, or Health and Mental Hydiene prior to burial, cremation, or removal.	
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within 24 hours after death. Page 6 may be retained by the	90e 5	9
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w requires that the death of	been signed by the attending physician and completely filled in by the it. of Health and Mental Hydiene prior to burial, cremation, or removal.	shows any injury or other traumatic event the medical examiner must be notified at once
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unba	en Si	how
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	1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND CERTIFICATE OF DEATH	MENTAL HYGIENE REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last) Marjorie Justine Knapp	2. DATE OF DEATH MONTH OCt. 17,	1995 3. TIME OF DEATH 9:15 AM M		
BE COMPLETED BY FUNERAL DIRECTOR	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (in yrs. last birthday) F UNDER 1 YEAR F UNDER 24 HRS. 215-22-5587 1 □ M 2 ☑ F 88 YRS. MONTHS DAYS HOURS MNN.	7. DATE OF BIRTN (Morth, Day, Year) 11-20-1906	BIRTNPLACE (State or Foreign Country)		
	99. FACILITY NAME (If not institution, give street and number) Calvert Manor Nursing Home RESIDENCE OF DECEMENT 99. CITY, TOWN OR LOCATION OF D RISING SUR		Cecil		
	MD Harford Havre de Gra	ce	10d. INSIDE CITY LIMITS? 1 X YES 2 NO		
	106. STREET AND NUMBER 1323 Superior Street 21078		USA		
	11. MARITAL STATUS 1 Never Married 2 Married 1 Never Married 2 Married 3 Wildowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO If YES, GIVE WAR OR DATES 13. WAS DECENDENT OF NISPA 14. WAS DECEDENT OF NISPA 15. WAS DECEDENT OF NISPA 16. WAS DECEDENT OF NISPA 17. WAS DECEDENT OF NISPA 18. WAS DECEDENT OF NISPA 19. WAS DECEDENT OF	en, Puerto Rican, etc.)	9 14. RACE American Indian, Black, White, etc. Specify: White		
	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) ACCOUNTING Technicia	18b. KIND OF BUSINESS	Government		
	17. FATHER'S NAME (First, Middle, Lest) Benjamin Walter 18. MOTNER'S NAME (First, Middle, Melden Surname) Marie C. Byrnes				
6	19a. INFORMANT'S NAME (Type/Print) Mrs. M. Jean Laye 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1323 Superior St., Havre de Grace, MD 21078				
	20b. METNOD OF DISPOSITION 1X) Buriel 2 Cremetion 3 Removal from State 4 Donetion 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 20b. PLACE AND DATE OF DISPOSITION (Name of completely, crematory or physic place) Angel Hill Cemetery 21. SIGNATURE OF FUNERAL SERVICE LICENSEE				
	Mitchell-Smith	h Funeral Ho ace, MD 21	me, P.A. 078-3197		
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, audience, or heart feliure. List only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) DUE TO (DR AS A CONSEQUENCE OF):	th as cardiac or respiratory	y arreat, Approximata interval Batween Onset and Death 5 ym.		
MEDICAL CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (DR AS A CONSEDUENCE OF): DUE TO (OR AS A CONSEDUENCE OF): d.				
	PART II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in	Part I. 24s. WAS AN AUTOI PERFORMED?	AMAILABLE PRIOR TO		
PHYSICIAN: MEDIC	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 126. PLACE OF DEATH (Check only one)				
YSIC	EXAMINER? 1 YES 2 NO				
ВУ РН	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation 26e. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28e. INJURY AT WORK? 1 YES 2 ND	26d. DESCRIBE NOW INJURY	OCCURED		
ETED	3 Suicide 6 Could not be determined 28e. PLACE OF INJURY — At home, farm, street, fectory, office building, etc. (Specify)	26f. LOCATION (Street end Nu. City or Town, Stete)	mber or Rural Route Number,		
COMPLETED	29. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner ee stated. 2 MEDICAL EXAMINER: On the best of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end menner ee stated.				
TO BE	296. SIGNATURE AND TITLE OF CERTIFIER 296. LICENSE NUI D-11115	MBER 29d.	DATE SIGNED (Month, Day, Year)		
	Neil R. Taylor Jr. P.O. Bax 459 - Rising Sun, M& 21911				
_	OCT 1 8 1995 Jahi Dawden Royall		DHMH-16 Rev 1/80		

TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 34 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burlal, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

4	TIE GIOTTUAT				PIXIII I	CAIL	- OF	DEAL	п	HEG. N	Ю.				
	1. DECEDENT'S NAME (First, Middle, Last) CHANG TOC			UNG	ENG Yong KIM			2. DATE OF DEATH DAY YE			3. TIME OF OEATH				
	4. SOCIAL SECURITY NUMB	-C111	5. SEX 6. AGE (In yrs. las		st birthday)	IF UNDER		IF UNDER		7. DATE OF BIRTH	-	8. BIRTHPLACE (State or Fo			
I.	216-92-1115 1⊠ M 2 □ F			57	YRS.	MONTHS	DAYS	HOURS	MIN.	Feb. 21,	1938	Kor	**		
_	Se. FACILITY NAME (If not institution, give street and number)					9b. CITY,	TOWN (OR LOCATIO				UNTY OF O	EATH		
5	Montgomery General Hospital					01	lney				Mor	Montgomery			
ᆲᅡ	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10					, TOWN O	R LOCAT	ION					10d. INSIDE CITY		
DIRECTOR	Maryland	Montgo	omery		Ro	ockvi	ille						LIMITS?		
	10e. STREET AND NUMBER							. ZIP CODE			10g. CI	TIZEN OF V	VHAT COUNTRY?		
<u> </u>	14716 Waterw	ay Dri	ive					2085	53		USA	Perm	. Resident		
	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced 12. WAS OCCEOENT EVER IN U FORCES? 1 YES IF YES, GIVE WAR OR DATI				RMED NO	H	f yes, sp	ENDENT O	ı, Mexicar	IC ORIGIN? (Specify 1, Puerto Rican, etc.)	fee or No-	E — American Indian, c, White, etc.			
	15. DECE	DENT'S EDUC	ATION	16a. D	ECEDENT'S	USUAL OC	CUPATIO	ON		16b. KIND OF E	USINESS/IN		sian		
COMPLETED	Elementary/Secondary (0-	highest grade (College (1-4 or 5 +		Give kind of w e. Do NOT us	rork done d e retired.)	during mo	st of working	7						
ÉL	12 4				Self-employed				Resta	urant					
3	17. FATHER'S NAME (First, Middle, Lest)				18. MOTHER'S NAME					ME (First, Middle, Maid	n Surname)				
Ä L	Jae Hoon Kim Ok Sun Shin														
o III	16a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)														
- 11-	Eun Sil Kim														
- 11	20a. METHOD OF DISPOSITION 13Z Burlel 2 Cremation 3 Removal from State 4 Donetton 5 Other (Specify)				PLACEAND OATE OF DISPOSITION (Name of Page Completely of other place) The Complete Memorial Park					OATE 20c. LOCATION — City or Town, State			wn, State		
- 20	21. SIGNATURE OF UNERAL		MOEE /	INOTDE	ск ме	mori	al l	ark	0.05.546	10/2801r	ley, N	<u>laryl</u>	and neral Home		
	· Xhely & Kensel					S	1800 ilve	New r Sp	Ham ring	pshire Av , Marylar	renue id 20	0904	neral Home		
	23. PART I. Enter the list	seeses, or co	omplications that	ceused the d	esth. Do n	ot enter	the mo	de of dyle	ng, such	sa cardiac or rea	piretory a	rreat,	Approximata		
	IMMEDIATE CAUSE (Find disease or condition resulting in death)	el	aw		my	000	ard	Lial		100	net.	00	Interval Between Onset and Death		
,															
CENTIFICATION	Sequentially list condition if any, leading to immediate. Enter UNDERLYIN														
2	CAUSE (Disease or Injur		OUE TO (OR AS A CONSE	OUENCE OF):									
	resulting in deeth) LAST					•									
- 11	PART II. Other algnificent conditions contributing to deeth but not resulting in the underlying ceuse given in Part i. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS														
EDICAL		PERFORMED? AWAILABLE PRIOR TO COMPLETION OF CAUSE									COMPLETION OF CAUSE				
		1 YES 2 NO OF DEATH?													
	DID TOBACCO US	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN													
	25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)														
5	HOSPITAL: 1 Inpatient 2 NO Inpatient 2 OTHER: 4 Nursing Home 5 Residence 8 Other (Specify)														
1000	27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Dey, Year) 28b. TIME OF 28c. INJURY AT WORK? WORK? 28d. DESCRIBE HOW INJURY WORK?									28d. DESCRIBE HOW	INJURY OC	CURED			
	\		28a. DATE OF (Month, Da	r, Year)	1 Netural 5 Pending (Month, Day, Year) INJURY WORK? 2 Accident Investigation M 1 YES 2 NO										
	1 Natural 5 P	ending	(Month, Da						NO						
5	1 Netural 5 P 2 Accident Ir 3 Suicide 8 C	ending	(Month, Da	(, Year) INJURY — At he to. (Specify)					NO	261, LOCATION (Stree City or Town, Sta		or or Aural A	oute Number,		
	1 Neturel 5 P 2 Accident Ir 3 Suicide 8 C 4 Homicide 6 29e. CERTIFIER (Check only 1 CERTII	Pending Investigation Could not be etermined FYING PHYSIC	(Month, De	INJURY — At he tc. (Specify)	ome, ferm, st	treet, facto	me, date	and place,	and due t	City or Town, Sta	e) enner se sta	ited.			
	1 Neturel 5 P 2 Accident Ir 3 Suicide 8 C 4 Homicide 6 29e. CERTIFIER (Check only 1 CERTII	hending twestigation could not be etermined FYING PHYSIC CAL EXAMINER	(Month, De	INJURY — At he tc. (Specify)	ome, ferm, st	treet, facto	me, date	and place,	and due t	City or Town, Sta	enner as sta	ited. he cause(a)	and manner as stated,		
	1 Netural 5 Pr 2 Accident 3 Suicide 8 C 4 Homicide 6 29e. CERTIFIER (Check only one) 2 SEEDIC	hending twestigation could not be etermined FYING PHYSIC CAL EXAMINER	(Month, De	INJURY — At he c. (Specify) my knowledge, de minetion and/or	ome, ferm, st	treet, facto	me, date	and place,	and due t	City or Town, Sta	enner as sta	ited. he cause(a)			
	1 Netural 5 Pr 2 Accident 3 Suicide 8 C 4 Homicide 6 29e. CERTIFIER (Check only one) 2 SEEDIC	rending restigation could not be etermined	28e. PLACE OF building, s 1AN: To the best of a: On the basis of exi	INJURY — At he rec. (Specify) ny knowledge, de sminstion and/or	path occurre	d at the tir	me, date	and place, seth occure	and due t	City or Town, Sta	enner as sta	nted. the cause(s) TE SIGNED	and manner as stated.		
	1 Neturel 5 Processor Proc	rending investigation could not be etermined FYING PHYSIC CAL EXAMINER OF CERTIFIER PERSON WHO	28e. PLACE OF building, s 1AN: To the best of a: On the basis of exi	INJURY — At he rec. (Specify) ny knowledge, de sminstion and/or	me, ferm, st path occurred investigation M 27) (Type,	treet, facto	me, date	and place, seth occure 29c. LICEI	and due to	City or Town, Sta	enner as sta and due to II	nted. the cause(s) TE SIGNED	and manner as stated,		
	1 Netural 5 Processor Proc	rending rendin	(Month, De 28e. PLACE OF building, e 1AN: To the best of r : On the best of exist.) COMPLETED CAUSE 32 REGISTRAF	INJURY — At he to. (Specify) my knowledge, do imination and/or V E OF DEATH (ITE	me, ferm, st path occurred investigation M 27) (Type,	d at the tir	me, date	and place, seth occure 29c. LICEI	and due to	City or Town, Sta	enner as sta and due to II	nted. the cause(s) TE SIGNED	and manner as stated.		

DIVISION OF VITAL RECORDS, P.O. BOX 68760

YEAR 95

9c. COUNTY OF DEATH

Montgomery

10g. CITIZEN OF WHAT COUNTRY?

United States

Specify:

3. TIME OF DEATH

0

10d. INSIDE CITY LIMITS?

RACE — American Indian, Black, White, etc.

20855

1 YES 2 NO

White

Approximata

Interval Betwe

24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE

1 - YES 2 NO

DF DEATH?

29d. DATE SIGNED (Month, Day, Year)

Be

OCT 24

A use

Onset and Death

Car

8. BIRTHPLACE (State or Foreign

Maryland

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REG. NO

2. DATE OF DEATH

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

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Helen OCT KING 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) 7. DATE OF BIRTH (Month, Day, Year DAYS HOURS 578-32-1886 1 M 2 3 F 75 August 8,1920 Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street end number 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR 7120 Roslyn Avenue Derwood RESIDENCE OF DECEDENT 10b. COUNT 10c, CITY, TOWN OR LOCATION Maryland Montgomery Derwood permit. 10e. STREET AND NUMBER FUNERAL 101. ZIP CODE use as the burial-transit 7120 Roslyn Avenue 20855 Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 THO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1 Never Married 2 Married TYES 2 XNO Specify BY 3 Widowed 4 Divorced 9 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only ET Elementery/Secondary (0-12) been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for it, of Health and Mental Hyglene prior to burial, cremation, or removal. College (1-4 or 5+) COMPL 12 Homemaker Own Home once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Melden Surneme) 듆 Harold Benjamin Simpson BE Carrie Virginia Smith notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code, 9 Harold J. King 7120 Roslyn Avenue, Derwood, Maryland must be 204. METHOD OF DISPOSITION
1 X Burlet 2 ☐ Cremetton 3 ☐ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Neme of cemetery, cremetory or other place) October 28,1995
Parklawn Memorial Park 20c. LOCATION — City or Town, State 4 Donation 5 Other (Specify) Rockville, Maryland the medical examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/Rockville, Inc., 300 W. Montgomery Ave Rockville, Maryland 20850-2805 M00348 23. PART I. Enter the diseeses, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one IMMEDIATE CAUSE (Final disease or condition arter iosclavotre executed within reaulting in death) traumatic event, DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disesse or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 0 injury, PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? апу OR ATTENDING PHYSICIAN; The law requires that 1 TYES 2 NO Shows PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square Dept. 23 has 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? After this certificate death with the State HOSPITAL OTHER: ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 8 Other (Specify) 10 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) marked, 28b. TIME OF 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED 1 Natural M 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, ferm, street, fectory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide .00 COMPLETED 8 Could not be DIRECTOR after 4 Homicide 28 hours 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(a) and menner as stated. TO THE FUNERAL D be filed within 72 h (Check only one) THE HOSPITAL 2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CENTIFIER 29c. LICENSE NUMBER BE D08:546 2 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

ber

32. REGISTRAR'S SIGNATURE

i Davoles Revolate

31. DATE FILED (Month, Day, Year)

OCT

2 7 1995

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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

BZIE WIS GMSIN

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	FOR STATE REGISTRAR	STATE OF MARY	LAND / DEPART			MENTA	L HYGIEN	E			
	1. DECEDENT'S NAME (First, Middle, La Thomas C	handler Keys				MONT	OF DEATH		YEAR	3. TIME OF DEATH 4:00 PM	
	4. SOCIAL SECURITY NUMBER 227-12-4273	5. SEX 6. AGE	, , , , , , , , , , , , , , , , , , , ,	IF UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	(Mont	OF BIRTH h. Day, Year) 7, 19		a. BIRTHPLACE (State or Foreign Country) Maryland		
HO.	90. FACILITY NAME (If not institution, gi 9110 Darnestown				R LOCATION OF DI	EATH		9c. COUNTY OF DEATH Montgomery			
DIRECTOR		0e. STATE 10b. COUNTY			on cville	10				10d. INSIDE CITY LIMITS?	
	10e. STREET AND NUMBER				. ZIP CODE 20850				EN OF WI	1 K YES 2 NO HAT COUNTRY? States	
BY FUNERAL	11. MARITAL STATUS 1 Never Merried 2 Merried 3XXWidowed 4 Divorced	1 Never Merried 2 Merried FORCES? 1X YES 2			ENDENT OF HISPAI ecity Cuben, Mexics 2 NO Specifi	n, Puerto			4. RACE	- American Indian, White, etc.	
ETED	15. DECEDENT'S E (Specify only highest gi	EDUCATION	16a. DECEDENT'S U	rk done during me		161	. KIND OF BU	SINESS/INDU	STRY		
COMPLET	12		Master	Plumber							
	17. FATHER'S NAME (First, Middle, Last)			18. MOTHER'S NA			Sumeme)				
DE L	Thomas Chan			Sue I							
2	190. INFORMANT'S NAME (Type/Print)	00			nd Number or Furni					0 20878	
	Sue Keys Margelos 15212 Gravenstein Way, North Potomac, Mi 20s. METHOD OF DISPOSITION 20b. PLACE AND DATE of DISPOSITION / 120b. PLACE AND DATE OF DISPOSITION / 120b. PLACE AND DATE OF DISPOSITION / 120b. PLACE AND DATE OF DISPOSITION / 120b. PLACE AND DATE OF DISPOSITION / 120b. PLACE AND DATE OF DISPOSITION / 120b. PLACE AND DATE OF DISPOSITION / 120b. PLACE AND DATE OF DISPOSITION / 120b. PLACE AND DATE OF DISPOSITION / 120b. PLACE AND DATE OF DISPOSITION / 120b. PLACE AND DATE OF DISPOSITION / 120b. PLACE AND DATE OF DISPOSITION / 120b. PLACE AND DATE										
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY ROBERT A. Pumphrey Funeral Home/Rockville, Inc., 300 W. Montgomery Ave Rockville, Maryland 20850-2805										
	23. PART 1. Enter the diseases, ahock, or heart failu IMMEDIATE CAUSE (Final disease or condition resulting in death)	re. List only one cause on	ed the death. Do not each line. al Infarct	cion-Ca			diac or reap	iratory arre	et,	Approximate Interval Between Onset and Death Minutes	
		Hyperten	*.	:						Years	
2	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury c.									Years	
CEMILIFICATION	that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): d.										
MEDICAL	PART II. Other eignificent conditions contributing to death but not resulting in the underlying cause Rheumatoid Arthritis, Renal Failure, Anemia						use given in Part I. 24s. WAS AN AUTOP PERFORMED? 1 □ YES 2 ₹ NO			24b. WERE AUTOPSY FINDINGS AMILLABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 X NO	
PHYSICIAN:	DID TOBACCO USE COI 25. WAS CASE REFERRED TO MEDICA		OF DEATH YES			иЦ					
210	EXAMINER?	HOSPITAL:	utpetient 3 DOA	OTHER:	se 5 XReeldence	6 🗆 Oth	er (Specify)				
5	27. MANNER OF DEATH	28e. DATE OF INJURY (Month, Day, Year,			JURY AT	28d. DE	SCRIBE HOW	INJURY OCC	URED		
2	1XXNetural 5 Pending 2 Accident Investigati 3 Suicide 8 Could not	RY — At home, farm, st		YES 2 NO		CATION (Street or Town, Stete		or Rural R	oute Number,		
COMPLEIED	const. only	HYSICIAN: To the best of my know								end menner se stated.	
	29b. SIGNATURE AND TITLE OF CERT				29c. LICENSE NU					(Month, Day, Year)	
2	Dorldas		ele so	2						r 24, 1995	
10	D27301 D27301 October 24, 1995 36. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Douglas R. Shumaker, M.D., 615 W. Montgomery Avenue, Rockville, Maryland 20850 31. DATE FILED (Month, Day, 18er) 12. REGISTRAR'S SIGNATURE 00 7 25 1995									nd 20850	

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

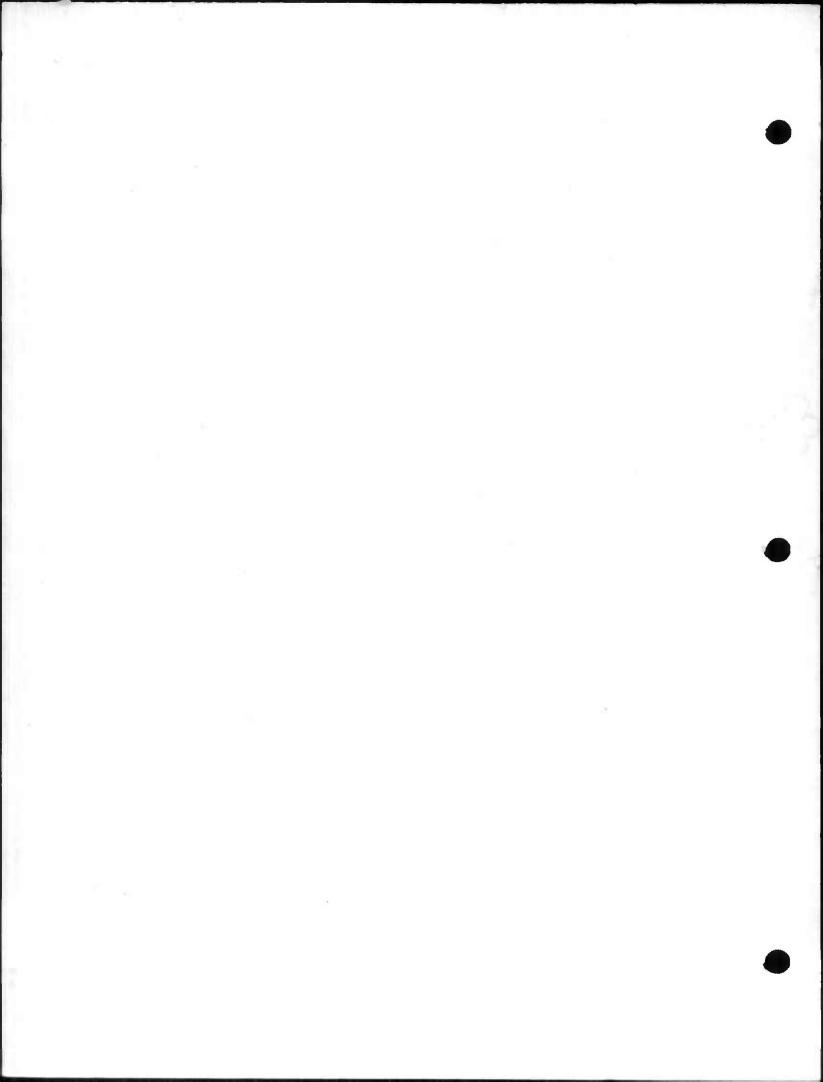
REGISTRAR		CERTIFI	CATE OF	DEATH	REG. NO).				
DECEDENT'S NAME (First, Middle, Last) Ba	rbara J. Ki	ser			2. DATE OF DEATH MONTH October 2	3, 1995	3. TIME OF DEATH 6:45 PI			
4. SOCIAL SECURITY NUMBER 478-20-6035	MONTHS DAYS HOURS MRM. (Month, Day, Year)						BIRTHPLACE (State or Foreign Country) IOWa			
9a. FACILITY NAME (If not institution, give s Wilson Health Car				rsburg	EATH	9c. COUNTY MOT	of DEATH otgomery			
RESIDENCE OF DECEDENT 100. STATE Maryland MC	ontgomery	10c, CITY	Gaithe	ersburg			10d. INSIDE CITY LIMITS? 1 YES 2 NO			
100. STREET AND NUMBER 420 Russell Avenu	le		101	20877			of what country?			
11. MARITAL STATUS 1 Never Married 2 X Married 3 Widowed 4 Divorced	1 Never Married 2 X Married FORCES? 1 YES 2				NIC ORIGIN? (Specify Wan, Puerto Rican, etc.) y:	pa or No 14.	. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) 3			ON st of working		USINESS/INDUST	TRY			
17. FATHER'S NAME (First, Middle, Last)										
Harold C. Jo	n Surname)									
19a. INFORMANT'S NAME (Type/Print)					Route Number, City or To					
Charles A. Kiser		420 R	ussell A	venue,	Gaithersbu	irg, Mar	cyland 20877			
20a. METHOD OF DISPOSITION 1										
21. SIGNATURE OF FUNERAL SERVICE LI		-	22. NAME A	O ADORESS OF FA	CILITYRobert	A. Pump	ohrey Funeral Montgomery Av			
Metastatic Lung Cancer DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):										
Todaling in county axo.	resulting in death) LAST									
PART II. Other aignificant conditions contributing to deeth but not resulting in the underlying cause given in						PERFORMED? 1 YES 2 X NO 24b. WERE A AWAILAE COMPLI OF DEA				
DID TOBACCO USE CONT	RIBUTE TO CAUSE	OF DEATH YE	S 🖾 NO E	UNCERTAI	N 🗆					
25. WAS CASE REFERRED TO MEDICAL EXAMINER?	TIGORITAL	26. PLACE OF DEAT								
1 VES 2XXNO	HOSPITAL: 1 Inpetient 2 ER/O	Y 286. TIM	E OF 28c. IN	URY AT	B Other (Specify) 28d. DESCRIBE HOW	/ INJURY OCCUR	RED			
1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year		M t 🗆	YES 2 NO						
3 Suicide B Could not be 4 Homicide determined	building, atc. (S	IRY — At home, farm, a pecify)	treet, factory, offic	•	281. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
CONSUM ONLY	(Check only 1 12 CENTIFTING PRESCIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIE	ker			29c. LICENSE NU D27830						
30. NAME AND ADDRESS OF PERSON WI Ramleth Shakir, I				, Gaithe	rsburg, Ma	aryland	20877			
31. DATE FILEO (Month, Day, Year) OCT 25 1995	32 REGISTRAR'S 61									

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FOR STATE REGISTRAR

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DIVISION OF VILAL RECORDS, P.O. BOX 66/10	0
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	1 - FOR STATE REGISTRAR	STATE OF N	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.									
	1. DECEDENT'S NAME (First, Middle SAMUEL	4.4	K0600					2. DATE OF DEATH DAY OCTOBER 20 1995				
~	4. SOCIAL SECURITY NUMBER 579-26-6063 90. FACILITY NAME (If not institution SUBURBAN HOSP		1 M 2 F 87 YRS. MONTHS DAYS HOUR limet and number) 9b. CITY, TOWN OR LOC				(Mont)	OF BIRTH h, Day, Year)	9c. COUNTY	OF DEAT		
Ď.	SUBURBAN HOSPITAL BETHESDA								MONTG	OMER'	Y	
DIRECTOR	10a. STATE 10b.	COUNTY MONTGOMERY	1.00.01.11.10.11					****			S. INSIDE CITY LIMITS? X YES 2 NO	
FUNERAL	100. STREET AND NUMBER 5600 WISCONSI	N AVE. #607				0001-					T COUNTRY?	
В	11. MARITAL STATUS 1 Never Merried 2 Marrie 3 Widowed 4 Divorced	FORCES? 1	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 2000 IF YES, GIVE WAR OR DATES			S DECENDENT OF HISPA ea, specify Cuban, Maxic YES X NO Speci	en, Puerto I			RACE — Bleck, Wi	American Indian.	
LETED	(Specify only highs Elementary/Secondary (0-12)	T'S EDUCATION set grade completed) College (1-4 or 5 d		life. Do NOT us	ork done du e retired.)	ing most of working		SINESS/INDUS				
COMPL	12 17. FATHER'S NAME (First, Middle, I	Last)		PROPR	IETOF	ts. MOTHER'S N	AME (First)		OR STO	RE		
BE C	CHARLES KOGO	*				BESSIE			Surrentay			
TO B	19e. INFORMANT'S NAME (Type/Pri EDITH KOGOD					SIN AVE. #					20815	
	20. METHOD OF DISPOSITION A Burlel 2 Cremetion 3 4 Donation 5 Other (Speci		20b. PLAC	AS ISR	AEL C	ON (Name of EMETERY	10-		SHINGT			
	21. SIGNATURE OF PRINTERAL SER	NICE LICENSEE	ne	-	DAN	ME AND ADDRESS OF F. ZANSKY—GOL O ROCKVILL	ACILITY DBERG	MEMO	RIAL CI	HAPEI	LS INC.	
CERTIFICATION	ahock, or heert fellure. List only one cause on each line. IMMEDIATE CAUSE (Fine) disease or condition.									Approximata Interval Between Onset and Deati I day I-2 days I-2 wk		
MEDICAL C	PART II. Other algolificent co		s contributing to deeth but not resulting in the underlying ceuse given in					PERFORMED? CC CC OI			RE AUTOPSY FINDINGS MILABLE PRIOR TO MPLETION OF CAUSE DEATH? YES 2 NO	
	DID TOBACCO USE (N 🗹					
SICIAN:	25. WAS CASE REFERRED TO MED EXAMINER? 1 YES 2 NO	HOSPITAL:		ACE OF DEAT	OTHER:							
РНУ	27. MANNER OF DEATH	28a. DATE OF	INJURY	28b. TIM		Bc. INJURY AT WORK?	_		INJURY OCCUP	ED		
TED BY	2 Accident Invest 3 Suicide 6 Could 4 Homicide determ	not be building,	OF INJURY — At atc. (Specify)	home, farm, s	treet, fector	t YES 2 NO		CATION (Street or Town, State	and Number or	Rural Route	e Number,	
COMPLET	one) —	G PHYSICIAN: To the best of EXAMINER: On the bests of a								ause(a) ar	od manner as stated.	
TO BE C	296. SIGNATURE AND TITLE OF C	ERTIFIER				29c. LICENSE NUMBER D37891					onth, Day, Year) 10 1995	
F	30. NAME AND ADDRESS OF PER 121 Congres:	sional Lu	1. 440	9 R	Print)	rille ma	2 2	085	2.		V.	
	31. DATE FILED (Month, Day, Year) OCT 26 199	32. REGISTE	AR'S SIGNATURI	Ц								



pe 6 may be retained by the hospital or attending physician. rector, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should TIMORE, MARYLAND 21215-0020

0 DIVISION OF VITAL BECORDS

BAL IIMORE, MARYLAND	ours after death. Page 6 may be retained by the hosp	d in by the funeral director, page 5 should be detached	medical examiner must be notified at once.
DIVISION OF VILAE RECORDS, F.O. BOX 68760	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the hours after death. Page 6 may be retained by the hosp	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached and within 70 hours after death with the Class Dam of Martin Language, price to having remarking or property of the funeral director, page 5 should be detached.	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once,

	FOR STATE REGISTRAR	STATE OF MARY	LAND / DEPA CERTII	RTMENT OF	HEALTH AND	MENTAL HYGIEI				
	1. DECEDENT'S NAME (First, Middle,	PAUL ART		LIMSTRO		2. DATE OF DEATH	DAY YEAR	3. TIME OF OEATH 12:45P.M		
	4. SOCIAL SECURITY NUMBER 473-24-8439		8. AGE (In yrs. last birthday)			7. DATE OF BIRTH (Month, Day, Year) 3-13-1	0. Bil	ATTHPLACE (State or Foreign unity) Innesota		
œ	9a. FACILITY NAME (If not institution, give atreet and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF							F OEATH		
DIRECTOR	203 SINGLETREE COURT WESTMINSTER CARROLL RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION									
	MARYLAND	ESTMINS				10d. INSIDE CITY LIMITS? 1 YES 2 NO				
FUNERAL	106. STREET AND NUMBER 203 SINGLETR	1	10f. ZIP CODE			F WHAT COUNTRY?				
UNE	11, MARITAL STATUS	12. WAS DECEDENT EVER FORCES? 1 XYES		13. WAS DE	21157 CENGENT OF HISPA	NIC ORIGIN? (Specify Ye	US na or No.— 14. R.	ACE — American Indian, lack, White, etc.		
B⊀	1 Never Married 2 Married 3 Wildowed 4 Divorced	If yes, 1	pecify Cuban, Maxic S 2 XNO Speci	an, Puarto Rican, etc.) fy:		eck, White, etc.				
TEO	15. DECEDENT'S (Specify only highest	grade completed)		S USUAL OCCUPAT work done during n		16b. KIND OF BU	JSINESS/INDUSTR	1		
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)		ager		State	Govern	nment		
	17. FATHER'S NAME (First, Middle, Las Arthur Paul					AME (First, Middle, Melder Pajari	n Surname)			
TO BE	19a, INFORMANT'S NAME (Type/Print)		19b. MAILIN	G ADORESS (Street		Route Number, City or Tox	wn, State, Zip Code)	-		
۲							rt, Westminster, Md. 21157			
	1 Buriel 2 Cremation 3 4 Donation 5 Other (Specify)	Removal from Stata Cei	b. PLACE AND DATE metery, cremetory or Anatomy	other place)	lame of		CATION — City of Baltimo	re, Md.		
	22. NAME AND ADDRESS OF FACILITY Fletcher E									
	23. PART I. Enter the diseases, shock, or heart falls	or complications that cause ure. List only one cause on a	d the dasth. Do	not antar the m	oda of dying, au	ch as cardiac or resp	piratory arrest,	Approximata Interval Between		
	immediate Cause (Final disease or condition resulting in death) a. Isclasse Heart Disease / mon									
Z	OUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, b.									
ATIC	if any, leading to immediata cause. Entar UNDERLYING	OUE TO (OR AS	A CONSEQUENCE	OF):						
CERTIFICATION	CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS	A CONSEQUENCE (OF):						
	PART II. Other algolificant cond	itions contributing to death i	out not resulting	In the underlyis	ng cause given in	Part I. 24s. WAS AN	AUTORCY To	4b. WERE AUTOPSY FINDINGS		
EDICAL	Dirbotes p	Leslitis		The diddinyn	ig cause given in	PERFO	RMED?	AMILABLE PRIOR TO COMPLETION OF CAUSE		
Σ								OF DEATH?		
HYSICIAN:	DID TOBACCO USE CO 25. WAS CASE REFERRED TO MEDICA	AL		ES LI NO L		N 🗆 📗				
YSIC	EXAMINER? 1 YES 2 NO	HOSPITAL: 1 Inpetiant 2 ER/Out	petlent 3 DOA	OTHER: 4 Nursing Ho	ne 5 Residence	8 Other (Specify)				
ву Рн	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigat	-		M 1	JURY AT ORK? YES 2 NO	28d. DESCRIBE HOW	INJURY OCCURED			
유	3 Suicide 6 Could not 4 Homicide determine		f — At home, term, cify)	street, factory, offi	CO	281. LOCATION (Street City or Town, State		ni Route Number,		
COMPLET	29a. CERTIFIER (Check only one) 1 CERTIFYING P 2 MEDICAL EXAM	HYSICIAN: To the best of my know MINER: On the best of exemination	riedge, death occur on and/or investigati	red at the time, dat on, in my opinion,	a and place, and due death occured at the	to the cause(s) and ma	nner as stiffed.	e(s) and manner as stated.		
H	296. SIGNATURE AND TITLE OF DERT				29c. LICENSE NUI	MBER 85	29d. DATE SIGN	EO (Month, Day, Year)		
2	Norman Gol as	who completed cause of de Lein, R.D. 21	8 WESLI	o. Print)	to Mell	285 Etr West	minde	40.		
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGN	IATURE				/ 5/-01	1		
	00121 3	13 Hava windles	Martall					DHMH.16 Rev 1/80		

DIVISION OF VITAL RECORDS, P.O. BOX 68760

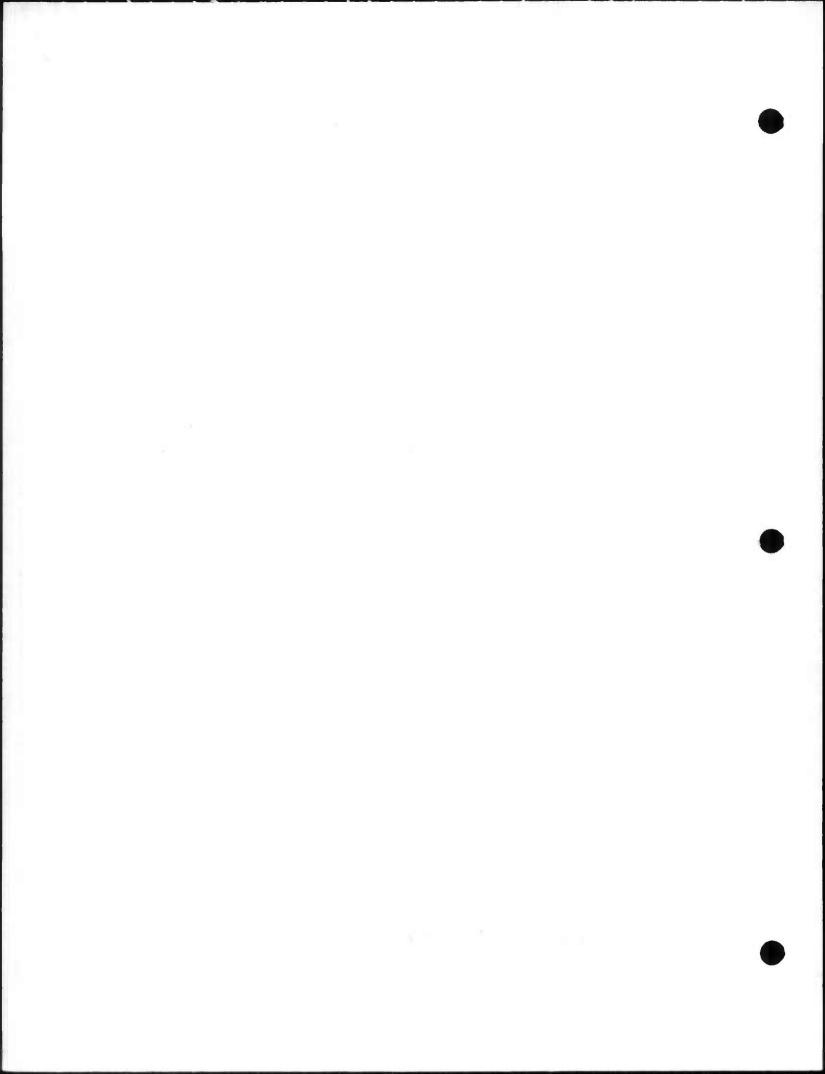
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

	REGISTRAL				SENTIF	ICAI	E OF	DEA	ΙП		REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last) LOMA MARIE				LONG				2. DATE OF DEATH MONTH DAY YEAR 7. TIME OF DEATH OCT - 2/, 1795 /2:05 /, N				3. TIME OF DEATH	
	4. SOCIAL SECURITY NUM		5. SEX	6. AGE (In yrs.	inst histories	IE IMPE	R 1 YEAR	IE IMPE	R 24 HRS.	-	E OF BIRTH	1		
	230-48-0282 1 M 2 XF 80 YRS.				MONTHS	DAYS				(Month, Day, Year)		BIRTHPLACE (State or Foreign Country) VIRGINIA		
	9e. FACILITY NAME (If not in			9b. CIT	Y, TOWN	OR LOCAT	ION OF DE	EATH		9c. COU	NTY OF D	EATH		
DIRECTOR	PENINSULA		AL MEDICA	AL CENT	ER	ER SALISBURY WICO					ICOM	CO		
Ĭ	10a. STATE 10b. COUNTY					Y, TOWN	OR LOCA	TION					T	10d. INSIDE CITY
	MARYLAND 100. STREET AND NUMBER	MICO	MICO		SAI	ISBU								LIMITS? 1 YES 2 X NO
¥						10f. ZIP CODE					10g. CFT	IZEN OF W	HAT COUNTRY?	
更	615 BOWMAN	DRIVE			21801						USA			
FUNERAL		11. MARITAL STATUS 12. WAS DECEDENT EVER			ARMED	13.	WAS DEC	ENDENT	OF NISPAN	IIC ORIG	IN? (Specify Yes	or No-	14. RACE	- American Indian,
	1 Never Married 2 Merried FORCES? 1 YES			WAR OR DATES	UNO				M, Mexica Specify		Rican, etc.)		Specif	, White, atc.
B	3 Widowed 4 Divo	rced							,				Opou.	WHITE
COMPLETED		EDENT'S EDUC y highest grade			DECEDENT'S	work done	during mo	ON st of workl	ng	16	b. KIND OF BUS	INESS/INI	DUSTRY	
PLE	Elementary/Secondary (0-12) College (1-4 or 5 +)			+)	ife. Do NOT use retired.) HOMEMAKER				П.	OWN HOM	TR			
N	17. FATHER'S NAME (Elms 4)	17, FATHER'S NAME (First, Middle, Lest)				·OTHI	MMCDI							
	HENRY VANCE										Middle, Maiden	Sumame)		
H									BRC					
2		19e. INFORMANT'S NAME (Type/Print)				ADDRES	S (Street e	nd Numbe	r or Rural I	Route Nur	nber, City or Town	, Stete, Zij	Code)	
٦	HARRY O. LO	NG			615 BC	WMAN	I DR	VE.	SALI	SBU	RY, MAR	YLAN	D 21	801
	20e. METHOD OF DISPOSIT				E AND DATE					DA			City or Tox	
	1 1 X Buriel 2 U Cremation 3 □ Removal from State cameton					SBORO REDMEN CEMETERY 10/25/95 DAGSBORO							•	
i	21. SIGNATURE OF RUMERA	L SERVICE LIC	ENSEE	1,		4			SS OF FA					
	/ Ma	les	WH	ug -	>~	H/	STI	IGS I	UNE	RAL	HOME, S	ELBY	VILL	E, DE. 19975
-	23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or reapiratory arrest, shock, or heart fellure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): Approximata interval Between Onset and Deeth Onset and Deeth Tears													
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): C. DUE TO (OR AS A CONSEQUENCE OF):													
	PART II. Other significs	nt conditions	s contributing to	deeth but no	t resulting	in the w	nderiving	COURA	ni nevin	Dort i	240 400 401	HITODOV	Lan	WERE AUTOPSY FINDINGS
EDICAL					but not resulting in the undariying ceuse given in F					Part i. 24a. WAS AN AUTOPSY PERFORMED?			- 3	AMAILABLE PRIOR TO COMPLETION OF CAUSE
											1 YES 2	300		OF DEATH?
Σ														1 YES 2 NO
z	DID TOBACCO U	SE CONTR	IBUTE TO CA	USE OF DE	ATH Y	S 🔲	NO X	UNC	ERTAIN	1 🗆				
PHYSICIAN:	25. WAS CASE REFERRED TO	MEDICAL		26. PL	ACE OF DEA	TH (Check	only one)							
ا ا	EXAMINER?		HOSPITAL:	ER/Outnations	3 🗆 004	OTHE			aldans	• [] ar	er (Specify)			
<u> </u>	27. MANNER OF DEATH		26e, DATE OF		28b. TIN		28c. INJ		sidence			III OO	011050	
BY PI	1 Netural 5	Pending Investigation	(Month, D		IN.	M	WO	RK?] NO	200. DE	SCRIBE NOW IN	JUHY OC	CURED	
ا ۵	3 Suicide 6	Could not be	28e. PLACE O	F INJURY — At etc. (Specify)	home, ferm,	street, fac	tory, office			201. LO	CATION (Street er or Town, Stete)	nd Number	or Aural A	oute Number,
9	29e. CERTIFIER . Aug.									-				
COMPLETE	(Check only	GAL EXAMINES	CIAN: To the best of : On the basis of ex-	my knowledge, camination and/o	death occurr or investigation	ed at the t	ifme, date opinion, d	end place	and due	to the ca	use(e) and mani e and place, and	nor ee atal	ed. e cause(e)	and manner se stated
1 20h NUMATUME AND TITLE OF OFFICIENT														
DO . DOLLO TOWNER (M.														
2	1 6			N.S				0.	300	690		0	ct. c	21,1995
	James B.	PERSON WHO		SE OF DEATH (IT	TEM 27) (Type	Print)						, ,	,	MD.
	31. DATE FILED (Month, Day,	Year)	32. BEGISTRA	AUGUATURE	0 0 0	3 6				-/	1 201	1.33	27	MD.
	UCT 2	4 1995	yalu d	audior !	ardall									

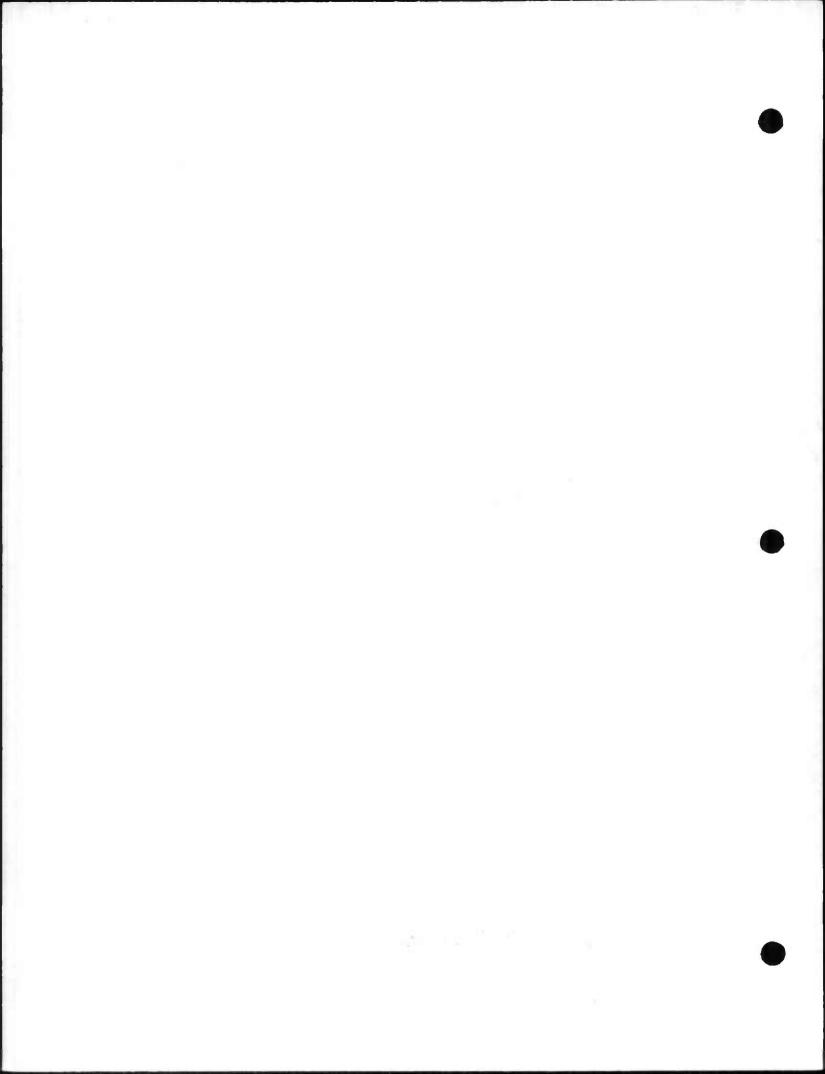


DIVISION OF VITAL RECORDS, P.O. BOX 68760

ir death. Page 6 may be retained by the hosp	he funeral director, page 5 should be detached.	examiner must be notified at once.	
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hosp	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.	
TO THE HOSPITAL OR ATTENDING P	TO THE FUNERAL DIRECTOR: After the filed within 72 hours after death v	IMPORTANT: If Item 28 Is marl	

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTA	L HYGIENI
CERTIFICATE OF DEATH	BEG NO

	FOR 1 - STATE REGISTRAR	STATE OF MAR	YLAND /	DEPAR	RTMENT	OF H	EALTH DE AT	AND M	ENTAL HYGIEN			00700
	1. DECEDENT'S NAME (First, Middle, Li	est)						T	2. DATE OF DEATH			3. TIME OF DEATH
	PAUL	JOHN			1	01	URL	1 1	OctoBES"	18 /	GON T	0415 A
	4. SOCIAL SECURITY NUMBER	5. SEX 6. A	GE (In yrs. last	birthday)	IF UNDER	1 YEAR	IF UNDER	24 HRS.	7. DATE OF BIRTH (Month, Day, Year)		8. BIRTI	IPLACE (State or Foreign
	216-44-4521	1 🔀 M 2 🗆 F	84	YRS.	MONTHS	DAYS	HOURS	MIN.	November 12	, 1910	Counti	m aryland
~	9a. FACILITY NAME (If not institution, gi				9b. CITY			ON OF DEAT	тн		NTY OF D	
0	PENINSULA REG		L CENT	CER		SA	ALISE	BURY		WI	COMI	.CO
DIRECTOR	10a. STATE 10b. COL			10c. CIT	Y, TOWN (OR LOCAT	ION					10d. INSIDE CITY
	Maryland W:	icomico		S	alis	bury						LIMITS?
IAL	10e. STREET AND NUMBER					101	ZIP CODE					WHAT COUNTRY?
FUNERAL	408 Pamela Dr						218	01		U	SA	
F	11. MARITAL STATUS 1 Never Married 2 X Married	12. WAS DECEDENT EVEN			13.	WAS DEC	ENDENT O	F HISPANIC	ORIGIN? (Specify Yes Puerlo Rican, atc.)	or No-	14. RACE Black	E American Indian, k, White, atc.
В	3 Widowed 4 Divorced	IF YES, GIVE WAR O	R DATES				2 🔀 NO		, , , , , , , , , , , , , , , , , , , ,		Speci	lly:
E	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) White White 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY							ce				
COMPLETED												
MP	12 I Supervisor Interstate Commerce								erce			
8	17. FATHER'S NAME (First, Middle, Last) William John Lowry								E (First, Middle, Maiden			
BE	William John Lowry Mary Ellen Kn											
2	196. INFORMANT'S NAME (Type/Print) 196. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 408 Pamela Dr., Salisbury, MD 21801											
	20a. METHOD OF DISPOSITION		20b. PLACEA					- 4220		CATION —		wn State
	1X Burial 2 Cremation 3 R 4 Donation 5 Other (Specify)	emoval from State	Parso	netory or o	ther plece)					alist		
	21. SIGNATURE OF PONERAL SERVICE	LICENSEE			22.	NAME AN	D ADDRES	S OF FACIL	LITY		, ,	
	1 /avec 9	1. Bomon							ral Home	isbu	rv.M	D 21801
	23. PART I. Enter the diseases, or complication that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or heart fallure. List only one ceuse on each line. Approximate interval Between											
	Interview IMMEDIATE CAUSE (Finel										Interval Between Onset and Daath	
	disease or condition resulting in death)	s. mult	iple	m	ye 1	mo	~					6 months
_		OUE TO (OR /	LS'A CONSEO	UENCE O	F):							
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	b DUE TO (OR /	S A CONSEO	UENCE OF	F):							
S	csuse. Enter UNDERLYING CAUSE (Disesse or injury	C										
E	that initiated events resulting in death) LAST	DUE TO (OR A	S A CONSEO	UENCE O	F):							
H	resulting in death) Exst	d										
AL O	PART II. Other significent condit	ions contributing to deet	h but not re	sulting	In the un	deriying	ceuse g	iven in Pa	art I. 24s. WAS AN	AUTOPSY	24b.	WERE AUTOPSY FINDINGS
PHYSICIAN: MEDIC	premone	, conges	hve	hear	+ +	ailu	uce		PERFOR		1	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
ME												1 YES 2 NO
ä	DID TOBACCO USE CON	TRIBUTE TO CAUSE					CUNC	ERTAIN				
20	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			OTHER	1:						
H X	1 YES 2 NO 27. MANNER OF DEATH	28a. DATE OF INJU		28b, TIM		ing Home			Other (Specify)	HIEW OO	CHRED	
ВУ Р	Natural 5 Pending	(Month, Day, Yea	ir)		URY M	WOI	RK?		ou. OLSOMBE HOW I	WONT OC	CONED	
100	3 Suicide 8 Could not I	28e PLACE OF IN I	JRY — At hon	ne, farm, s	street, facto	ory, office		2	St. LOCATION (Street a	nd Number	or Rural R	oute Number,
COMPLETED	4 Homicide datarmined		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,						City or Town, State)			
29a. CERTIFIER (Check only CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.												
one) 2 MEDICAL EXAMINER; On the beals of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and menner as stated								and menner as stated.				
296. SIGNATURE AND TITLE OF CHITISHER 29d. DATE SIGNEO (Mgnth, Day, Year)								(Month, Day, Year)				
2	CPart SK	m					D	308	7.3	1	0/18	19]
	30. NAME AND ADORESS OF PERSON	WHO COMPLETED CAUSE OF	DEATH (ITEM		Prine) PRM	C						
	31. DATE FILED (Month, Day, Year)	32 MEGISTRAR'S S	IGNATURE)		+ + (_					
	OCT 23 19	32. MEGISTHAR'S S	you Ran	delle								



TO BE COMPLETED BY FUNERAL DIRECTOR

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Dorilda Letendre	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL	L
1 - STATE REGISTRAR	CERTIFICATE OF DEATH	F

STATE REGISTRAR	STATE OF MARY	(LAND / DEPART	TMENT OF I		MENTA	L HYGIENE REG. NO.			
1. DECEDENT'S NAME (First, Mick DORILDA		DRE			MONT	of DEATH DAY		YEAR 95	3. TIME OF DEATN 1:10 A
I. SOCIAL SECURITY NUMBER		SE (In yrs. lest birthday)	MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE (Monti	OF BIRTN h, Day, Year)		8. BIRTH	PLACE (State or Foreign
061-10-6469	1 🗌 M 2 🗶 F	83 YRS.				17, 1			NECTICUT
a. FACILITY NAME (If not institute			OR LOCATION OF D	EATN		9c. COUN			
Salisbury Nur	sing & Rehab Ce	enter			Wic	omic	10		
	COUNTY	10c. CITY	, TOWN OR LOCA	TION					10d. INSIDE CITY
MD	WICOMICO	SA	ALISBURY	7					1X YES 2 NO
e. STREET AND NUMBER			10	t. ZIP CODE			10g. CITIZ	EN OF W	NAT COUNTRY?
834 SCHUMAKE	R DRIVE, APT. 1	.03		21801			US	SA	
. MARITAL STATUS X Never Married 2 Meri Widowed 4 Divorced	12. WAS DECEDENT EVE FORCES? 1 YE IF YES, GIVE WAR OF	ES 2 X NO	If yes, sp	CENDENT OF NISPA healfy Cuben, Mexic 3 2 X NO Speci	en, Puerto		or No-		— American Indian, White, etc.
15. DECEDER	NT'S EDUCATION hest grade completed)	16e. DECEDENT'S	USUAL OCCUPATE	ON ast of warking	168	. KIND OF BUS	INESS/IND	USTRY	
Elementary/Secondary (0-12)	College (1-4 or 5+)	Ille. Do NOT us	e retired.)						
8		HOMEMA	AKER				N HOM	1E	
FATHER'S NAME (First, Middle,				16. MOTNER'S NA					
	LETENDRE					LeMONI			
e. INFORMANT'S NAME (Type/F				and Number or Rural					21001
ARTHUR B. LE				LANE, API					
a. METNOD OF DISPOSITION Burlal 2 X Cremation	☐ Flemovel from State	20b. PLACE AND DATE Of cemetery, crematory or of SALISBI	OF DISPOSITION (N	ame of	1	20c. LOC			
☐ Donation S ☐ Other (Spe I. SIGNATURE OF) PORERAL SE		SALISDI	The state of the s	ND ADDRESS OF FA		14 SA	LISDU	KI,	rin -
3. PART I Enter the disea ahock, or heart MMEDIATE CAUSE (Final lisease or condition eaulting in death)	sea, or complications that cause of failure. List only say cause of	n each line.	not anter the me	Ode of dying, aud	ch aa car	diac or reapis	atory am	ent,	Approximata Interval Batwe
sequentially list conditions f any, leading to immediat ause. Entar UNDERLYING AUSE (Disease or Injury hat initiated events	bDUE TO (OR A	AS A CONSEQUENCE OF	F):						
	d. conditional contributing to deat),	in the underlying			24e. WAS AN PERFOR 1 — YES 2	MED?	24b	WERE AUTOPSY FINDING AMAILABLE PRIOR TO COMPLETION OF CAUSE OF GEATH? 1 YES 2 NO
5. WAS CASE REFERRED TO MI EXAMINER?		26. PLACE OF DEAT)					
1 VES 2 NO	HOSPITAL: 1 Inpatient 2 ER/	Outpetient 3 DOA	A Nursing No	me 5 🗆 Residence	6 🗆 Oth	er (Specify)			
7. MANNER OF OEATH			JURY W	JURY AT ORK? YES 2 NO	26d. DE	SCAIBE NOW IF	JURY OCC	CURED	
3 Suicide 6 Cou	26e. PLACE OF INJ building, etc. (URY — At home, farm, a Specify)				CATION (Street e or Town, Stete)	nd Number	or Rural I	Route Number,
const. orny	NO PHYSICIAN: To the best of my k EXAMINER: On the basis of examin				e time, dat		d due to 1h	e ceuse(i	o) and manner so stated (Month, Day, Year)
	HSON WNO DMPLETED CAUSE OF L'EGMAN, M.D., M			INCESS A	NNE -	MD.	21853		
1. DATE FILED (Month, Day, Year	32. REGISTRAR'S S	GIGNATURE							
OCT 18		400 Rardall							

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

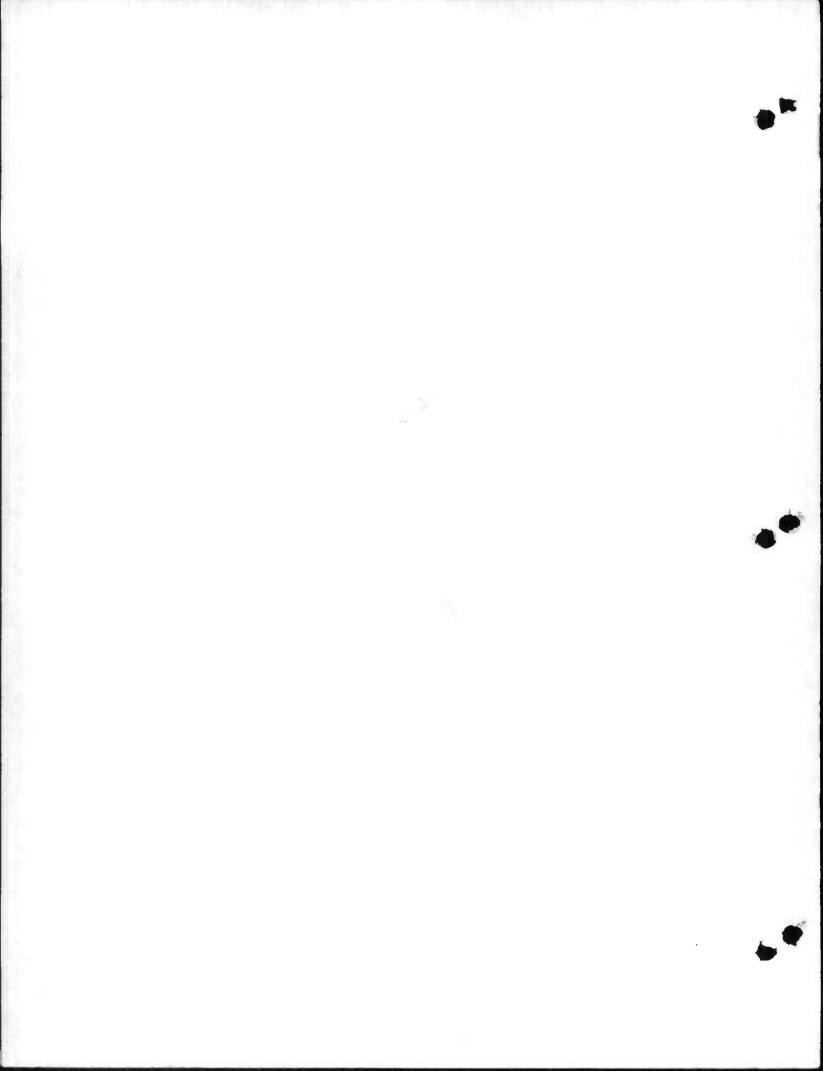
DIVISION OF VITAL RECORDS, P.O. BOX 6876/

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit, Pages 1, 2, 3 should	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once
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	FOR	0717F 0F 144 PM					95	33708			
	1 - STATE REGISTRAR	STATE OF MARY		MENT OF HI CATE OF I		MENTAL HYGIE REG. N					
	1. DECEDENT'S NAME (First, Middle, Last)	-		0	D	2. DATE OF DEATH		3. TIME OF DEATH			
	Lillian Elizab	12:45 a M									
	4. SOCIAL SECURITY NUMBER	A 100 100 100 100 100 100 100 100 100 10	(In yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	10-24- 7. DATE OF BIRTH (Morth, Day, Year)		BIRTHPLACE (State or Foreign Country)			
	213-05-1146	1 🗆 M 2 🔀 F	90 YRS.			7-26-19	05	Maryland			
l œ	Sa. FACILITY NAME (If not institution, give at			9b. CITY, TOWN OF	LOCATION OF DE	ATH	9c. COUNT	Y OF DEATH			
6	106 Magnolia A	venue		Pasade	na		Anne	Arundel			
REC	10a. STATE 10b. COUNTY		10c. CITY,	TOWN OR LOCATIO	ON			10d. INSIDE CITY			
0		e Arundel	Pas	adena				1 YES 2X NO			
BY FUNERAL DIRECTOR	10e. STREET AND NUMBER			101.	ZIP CODE		10g. CITIZE	EN OF WHAT COUNTRY?			
N.	106 Magnolia A										
E	1 Never Married 2 Married	12. WAS DECEDENT EVER FORCES? 1 YES	2 X NO	If yes, spec	olfy Cuban, Mexica	NC ORIGIN? (Specify) n, Puerto Rican, etc.)	fea or No— 1	4. RACE — American Indian, Black, Whita, etc.			
	3 🔀 Widowed 4 🗌 Divorced	IF TES, GITE THAT ON L	DATES	1 L TES 2	NO Specify	r:		Specify: White			
<u> </u>	15. DECEDENT'S EDUC (Specify only highest grade		16a. DECEDENT'S U	rk done during most	of working	18b. KIND OF B	USINESS/INDU				
ja ja	Elementary/Secondary (0-12)	College (1-4 or 5+)	iife. Do NOT use	retired.)	or morning						
COMPLETED	17. FATHER'S NAME (First, Middle, Last)		Homema				me				
	Unknown Pumphi	2017				ME (First, Middle, Maide					
BE	19a. INFORMANT'S NAME (Type/Print)	еу	19b. MAILING A	DDRESS (Street and		e Nighte		hydel			
2	Anna Mae Vermil	llion				e Pasade					
100	20a. METHOD OF DISPOSITION 1√2 Burial 2 □ Cremation 3 □ Remo	20	b. PLACE AND DATE OF	DISPOSITION (Nam				ty or Town, State			
	4 Donation 5 Other (Specify)	00.	metery, crematory or othe len Have		terv 1	0-26-95	Glen	Burnie, MD			
	21. SIGNATURE OF FUNERAL SERVICE LIC	PHSEE	1								
ave	> POTOUS K	Barranco and Sons Funeral Home 495 Ritchie Hwy Severna Park MD 2114 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate									
	23. PART i. Enter the diseases, or c shock, or heart failure.	omplications that cause	d the death. Do no	t enter the mod	e of dying, such	aa cardiac or rea	piratory arres	et, Approximate			
E	shock, or heert fallure. List only one ceuse on each line. iMMEDIATE CAUSE (Final disease or condition) CEREBRAL VASCULAR ACCIOENT										
2				ncan n				interval Between			
11	iMMEDIATE CAUSE (Final disease or condition resulting in death)	CEREB	RAL VI					interval Between			
	disease or condition	DUE TO (OR AS	RAL VI					interval Between			
TION	disease or condition resulting in death)	DUE TO (OR AS A HYPER	RAL VI	8				interval Between			
CATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A HYPER	RAL VI A CONSEQUENCE OFF:	8				interval Between			
TIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events	DUE TO (OR AS	RAL VI A CONSEQUENCE OFF:	5 N				interval Between			
SERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury	DUE TO (OR AS	RAL VI A CONSEQUENCE OF): A CONSEQUENCE OF):	5 N				interval Between			
5 0	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events	DUE TO (OR AS A DUE TO (OR AS	A CONSEQUENCE OF): A CONSEQUENCE OF): Dut not resulting in	2	A A	Part I. 24a. WAS A	N AUTOPSY	interval Between Onset and Death 24b. WERE AUTOPSY FINDINGS			
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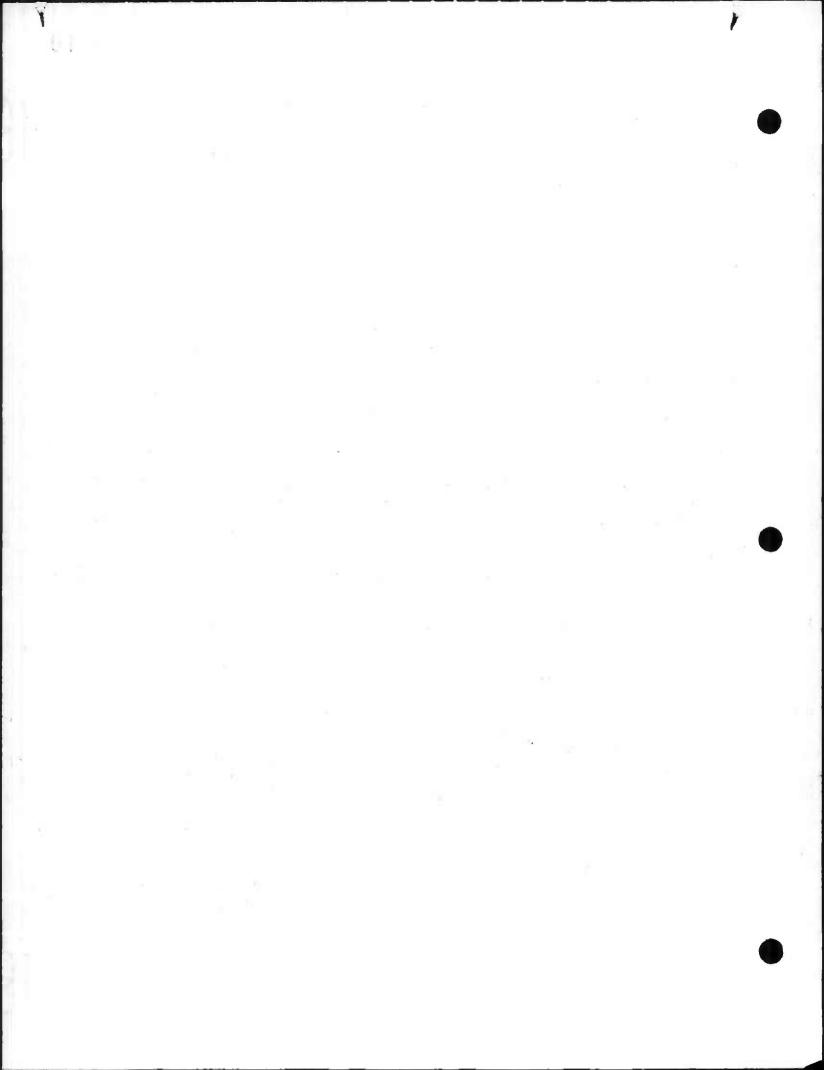
32. REGISTRAR'S SIGNATURE

CERTIFICATE # 95333051



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DIVISION OF VITAL	

		1 - STATE REGISTRAR	TATE OF MARYLAND	D / DEPART	MENT OF H	FEALTH AND N	MENTAL HYGIEN		
		1. DECEDENT'S NAME (First, Micdile, Last)	0.	16	Hm	AN	2. DATE OF DEATH MONTH	AY_ YEAR	3. TIME OF DEATH
pj		162-18-3213	□ M 2 🔀 F 86	(last birthday)	MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Morth, Day, Year) November	3,1908	RTHPLACE (State or Foreign Pennsylvania
2, 3 should	OR	9a. FACILITY NAME (If not institution, give street a Washington Adventis	st Hospital		Takom	or Location of DE	ATH	Montgo	
permit. Pages 1,	DIRECTOR	10a. STATE 10b. COUNTY Maryland Prince (Georges		TOWN OR LOCAT			0	10d. INSIDE CITY LIMITS? 1 🗡 YES 2 🗌 NO
. usit	FUNERAL	100. STREET AND NUMBER 6703 Conway Ave.				ZIP CODE 20912		109. CITIZEN OF	F WHAT COUNTRY?
21215-0020 al or attending physician. for use as the burial-transit	E E	1 Never Married 2 Married	WAS DECEDENT EVER IN U.S. FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES	ARMED X NO	If yes, sp	ENDENT OF NISPANI ecity Cuban, Mexican 2 NO Specify	C ORIGIN? (Specify Yes , Puerto Rican, etc.)	or No.— 14. R/	ACE — American Indian, lack, White, etc.
21 10 10 10	COMPLETED	15. DECEDENT'S EDUCATIO (Specify only highest grade comp Elementary/Secondary (0-12) Co	oleted) illege (1-4 or 5+)	DECEDENT'S U (Give kind of we life. Do NOT use atalogu	USUAL OCCUPATION ork done during monotone interest.)	DN st of working		siness/industry	
Z 2 2	111 05	17. FATHER'S NAME (First, Middle, Last) Orin Swope					E (First, Middle, Maiden Dickey	Surname)	
IE, MAR ay be retained t page 5 should	TO BE	196. INFORMANT'S NAME (Type/Print) Vaughn Lehman		19b. MAILING / 8611 F	Riggs Ro	nd Number or Rural Rel. Adelph:	i, MD 207	n, State, Zip Code) 83	
ALTIMORE Beath. Page 6 may funeral director, pag	n must b	20a. METHOD OF DISPOSITION V Burle! 2 Crematton 3 Removal f 4 Denation 5 Other (Specify)	From Span	CE AND DATE OF COMPANY OF OTH LOCAL COMPANY OF COMPANY	F DISPOSITION (Na DF Cemet	ery (oct.22,199	cation — city or 95 Berli	
BALTIMORE, after death. Page 6 may be y the funeral director, page noval.	medical examiner must	FUNERAL SERVICE LICENSE	Telball	4	254 Ca	arroll St	Takoma F . NW Washi	ington, D	Home, Inc. O.C. 20012
760 ed within 24 in completely fille	ry, or other traumatic event, the medical CERTIFICATION	23. PART L Enter the diseases, or companded, or beet failure. List of IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	Conges	ISEQUENCE OF)	Car		as cardioc or respi taile ren cha		Approximate interval Between Onset and Death Seuf Weeks
OS, P.O. he death certif the attending Mental Hygien	CERTIF	that initiated events resulting in death) LAST							
A the and white and white	shows any injury. MEDICAL CI	Bed ridge	due to	gen	ralise	1 Arth		MED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
law law	PHYSICIAN:	DID TOBACCO USE CONTRIBU 25. WAS CASE REFERRISO TO MEDICAL EXAMINER?		LACE OF DEATH	(Check only one)	UNCERTAIN			
OF VIT, PHYSICIAN: Th this certificate with the State		1 YES 2 NO 1 27. MANNER OF DEATH	npetient 2 ER/Outpetient 28s. DATE OF INJURY (Month, Day, Year)		OF 28c, INJI	RK?	Other (Specify) 28d. DESCRIBE NOW IN	JURY OCCURED	
) 5 4 5	m 28 is mar ETED BY	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide etermined	28a. PLACE OF INJURY — At building, atc. (Specify)	t home, farm, str		ES 2 NO	281. LOCATION (Street a City or Town, State)	nd Number or Rurs	al Route Number,
TAL OR TAL DIR			To the best of my knowledge, the basis of examination and/						e(a) and manner as stated.
TO THE HOSPITAL TO THE FUNERAL De filed within 72 I	B B	296. SIGNATURE AND TITLE OF CERTIFIER	mi MD			29c. LICENSE NUME			ED (Month, Day, Year)
)	₽	30. NAME AND ADDRESS OF PERSON WHO COM MOBARAK KARI	M. 7610 CI	ARRO		ESTE3	40, TAKON	1A PAR	K,MD 20912
_		31. DATE FILED (Month, Day, Year)	32 REGISTRAR'S, SIGNATURE						



TO THE HOSPITAL OR ATENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNEFAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State begt, of Health and Marial Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the marial examiner must be marified at pages. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

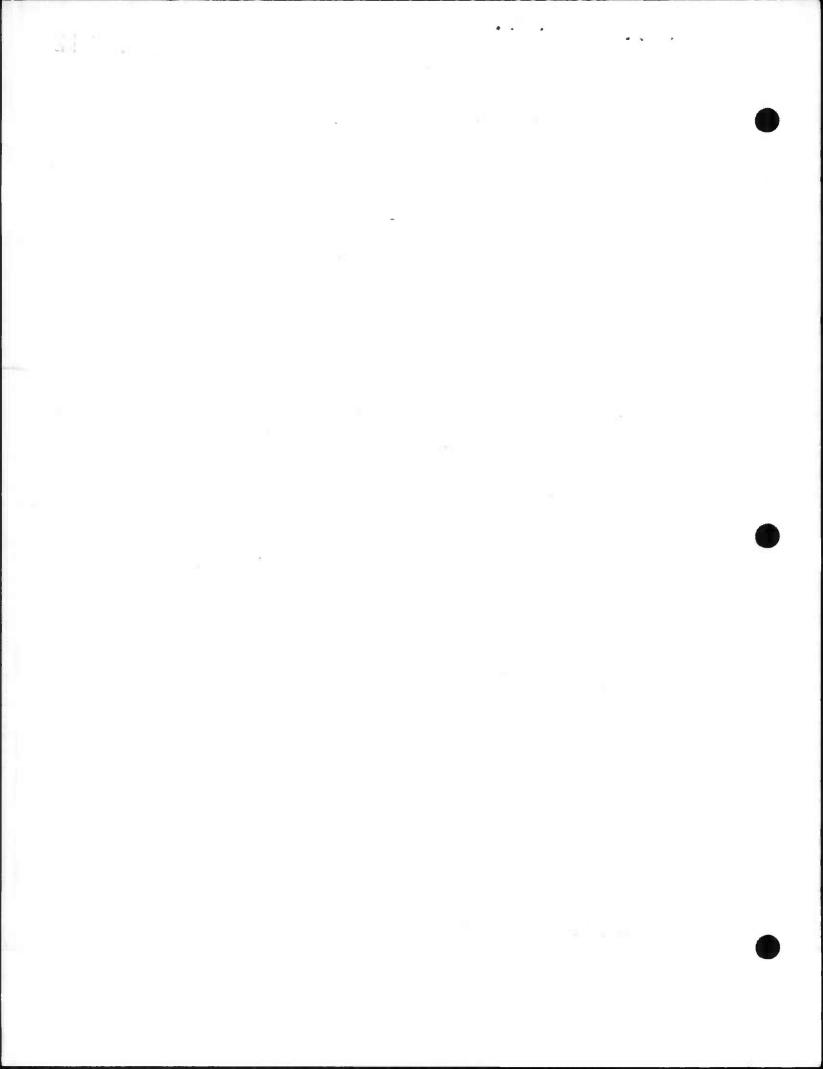
FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

		1. DECEDENT'S NAME (First	t, Middle, Last)	*								2. DATE OF D	EATH			3. TIME OF DEATH
		/	MILDR	ED MA	RY		1	400	TT			OCT. 1	D/	1995	YEAR	2:35 p M
	1	4. SOCIAL SECURITY NUM	BER	5. SEX	6. AGE	(In yrs. last	birthday)	IF UNDE	1 YEAR	IF UNDE	1 24 HRS.	7. DATE OF BI	RTH		e. BIRTI	HPLACE (State or Foreign
		213.74.3197	7	1 M 2 X F		92	YAS.	MONTHS	DAYS	HOURS	MIN.	DEC. 12		02	PEN	NSYLVANIA
		9a. FACILITY NAME (If not institution, give street and number)							9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH							
g	5	HOLY CROSS	HOSP	ETAL					SILV	ER SI	PRING	3		MONTGOMERY		
3		RESIDENCE OF DEC	10b. COUNT	y			100 017	ITY, TOWN OR LOCATION								
DIRECTOR		MARYLAND	MONTGO					COMAC		ION						10d. INSIDE CITY LIMITS?
		10e. STREET AND NUMBER					10.			I. ZIP COD	E			10+ OT	IZEN OF I	1 A YES 2 NO
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BY E		IF VES CIVE WAR OR DATES							If yea, sp	ecity Cubs	n, Mexican Specify:	n, Puerto Ricen,	etc.)		Spec	k, White, atc.
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1 4		Elementary/Secondary (0-12) College (1-4 or 5 +) +-4 HOM										0	LINI 1	HOME		
NO O		17. FATHER'S NAME (First, M	ficidle, Last)			MOIL				10 MOT	HED'S MAA	WE (First, Middle,				
E U		THOMAS P.	THORN	NTON						10. 1101		RY TIM		Sumame)		
		19a. INFORMANT'S NAME (Type/Print)			19b	MAILING	ADDRES	S (Street a	and Number		loute Number, Cit		n. State. Zie	Code)	
2		JOSEPH LYNC	TT									HESDA,				
		20a METHOD OF DISPOSIT	ION	oval from State		D. PLACE A							20c. LO	CATION -	City or To	own, State
		4 Donation 5 Other	(Specify)	_	G	NTE C	FTHI									NG, MD.
	ı	21. SIGNATURE OF FUNERA	L SERVICE LIC	EHREE))				22. NAME AND ADDRESS OF FACILITY JOSEPH GAWLERS SONS							
		5130 WISCONSIN AVE. N.W. WASHINGTON D.C.									GTON D.C.					
		23. PART. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.														
		IMMEDIATE CAUSE (Final Onset and Death														
2		disease or condition resulting in death) a. Angelieration arrest														
2		DUE TO (OR AS A CONSEQUENCE OF);														
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ő		one) 2 MEDI	CAL EXAMINE	R: On the besis of ex	aminatio	n and/or in	rvestigatio	n, in my o	pinion, d	eath occur	ed at the t	ime, date and p	lace, and	due to th	e cause(a) and manner as stated.
BE	I	29b. SIGNATURE AND TITLE	OF CENTIFIER	6	1					29c. LICE	NSE NUM	BER	T	29d. DAT	E SIONED	(Month, Day, Year)
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1		20. NAME AND ADDRESS OF	PERSON WHI	COMPLETED CAUS	E OF DE	ATH (ITEM	27) (Type.	Print)	0.0	1	. 0	UVFD	Suc	PING	И.	20902
	-	SICHARD J. 31. DATE FILED (Month, Day.	UEL!	100000000000000000000000000000000000000	11).	78	019	EOR	7/4	HVE) 3	ILFLK	J/ K	179	110	20702
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DALLINONL, MANICANL	24 hours after death. Page 6 may be retained by the hosp	y filled in by the funeral director, page 5 should be detached from or removal	the medical examiner must be notified at once.
	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Z4 hours after death. Page 6 may be retained by the hosp	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached be filed within 72 hours after death with the State Deot, of Heath and Mental Housine prior to burial, cremation, or removal	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

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296. LICENSE NUMBER 296. LICENSE NUMBER 296. LICENSE NUMBER 296. LICENSE NUMBER 296. LICENSE NUMBER 296. LICENSE NUMBER 297. OATE SIGNED (Morriph, Dep. 207.) 10/30/95 30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE Of DEATH (ITEM 27) (Type, Print) Dr. Sally Habib, 120 Sister Pierre Dr., Towson, MD 21204	29e. CERTIFIER (Check only Check only International Check on Check only International Check on									ause(e) end man	ner ee sts	ted,			
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30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Sally Habib, 120 Sister Pierre Dr., Towson, MD 21204	BE	and the second s	8.0		Way W	JD.									
Dr. Sally Habib, 120 Sister Pierre Dr., Towson, MD 21204 31. DATE FILED (MONTH, Day, 1995) 32. July Habib, 120 Sister Pierre Dr., Towson, MD 21204	۲	30. NAME AND ADDRESS OF	PERSON WNO	COMPLETED CAUS	SE OF DEATH (ITEM 27) (Type,	Print)								
NOV 0 6 1995 Jan 20 1995		Dr. Sally	Habi	b, 120	Siste	er Pi	erre	Dr	• ,	rows	son	, MD 2	120	4	
		NOV	15 199	5 Julia		Flantall									



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		1 - FOR STATE OF REGISTRAR	MARYLAND / DE	PARTMENT OF H	HEALTH AND M	IENTAL HYGIEN					
		1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH MONTH D	AV VEAU	3. TIME OF DEATH			
		Bonnie B. McGee				October	26 195	0023 м			
P		4. SOCIAL SECURITY NUMBER 5. SEX 1 □ M 2 □ F	6. AGE (In yrs. lest birt	rrs. FUNDER 1 YEAR DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Sept 26	Cour	THPLACE (State or Foreign ntry) Kansas			
3 should	Œ	9a. FACILITY NAME (If not institution, give street and number) Carroll County Gener	al Hospi		minster	TH	9c. COUNTY OF				
1, 2,	100	RESIDENCE OF DECEDENT	ar nospr	our. Hest	MINISTEL		Carr	011			
UZU physician. burial-transit permit, Pages 1,	DIRECTOR	Maryland Carroll	10	Westmins			- 1	10d. INSIDE CITY LIMITS? 1 YES 2 1 NO			
rit permi	FUNERAL	10. STREET AND NUMBER 3739 Turkeyfoot Road		10	21158	P - 1	WHAT COUNTRY?				
cian. Ftrans	N.		ENT EVER IN U.S. ARMED	13 WM C DEC		C ORIGIN? (Specify Yes		d States			
P 2 2	ETED BY	1 Never Married 2 Married FORCES?	1 YES 2 NO WAR OR DATES	If yes, sp	ecity Cuban, Mexican, 2 X NO Specify:	Puerto Rican, etc.)	Bla	CE — American Indian, lick, White, atc.			
r attend use as		15. DECEDENT'S EDUCATION (Specify only highest grade completed)	(Give ki	ENT'S USUAL OCCUPATION	ON set of working	16b. KINO OF BU	ISINESS/INDUSTRY				
of for		Elementary/Secondary (0-12) College (1-4 or 1 2	5+)	NOT use retired.)		Dande					
he hospit detached once.	COMPL	17. FATHER'S NAME (First, Middle, Last)	wor	Kei	18. MOTHER'S NAM	E (First, Middle, Maiden	1 House				
2 2 E	BE C	unknown					gire				
retained by 5 should b	0 8	19a. INFORMANT'S NAME (Type/Print)		AILINO ADDRESS (Street a							
may be not page 5 ast be no	-	Frederic Foley		5 Oakwild							
Bector, p		28a, METHOD OF DISPOSITION 1	Cometery, Cremato	DATE OF DISPOSITION (Na ry or other piece)			CATION — City or				
		21. SIGNATURE OF FUNERAL SERVICE LICENSEE	- I Westm	inster Ce	ND ADDRESS OF FACI	LITY		ter, MD			
		+ Yaku i Pik	1. mitara			eral Hom					
by the		23. PART I. Enter the diseases, or complications to	het couppil the deeth.	Do not enter the mo	de of dving, such	as cardiac or respi	, West	minster, MI			
D D D E		ahock, or haert failure. List only one c IMMEDIATE CAUSE (Finel	ause on aach ilne.		, , ,			Interval Batween Onset end Death			
d within 24 ompletely fille i, cremation, the event, the		disease or condition resulting in death)	OPD					7/0mps.			
8 5 - 6		DUE	TO (OR AS A CONSEQUEN	ICE OF):							
and and last	CATION										
ficate be ex physician a ne prior to	S	cause. Enter UNDERLYING CAUSE (Disease or Injury									
the death certificate the attending physical Mental Hygiene principality, or other to	RTIF	that initiated events resulting in deeth) LAST	O (ON AS A CONSEQUEN	ICE OF):							
the death y the attend nd Mental	CE	DADT il Other significant conditions contain de									
- 69 -	CAL	PART II. Other aignificent conditions contributing \$\tilde{\mathbb{U}} \mathbb{A} \text{ \$\tilde{\mathbb{U}} \mathbb{E} \text{ \$\tilde{\mathbb{U}	S deeth but not result	iting in the underlying	g ceuse given in P	art I. 24a. WAS AN PERFOR		b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO			
w requires that been signed by, of Health a	MEDIC	A LCVHO		DISCUSE		1	QKND	OMPLETION OF CAUSE OF DEATH?			
e law req has been Dept. of 23 sho	AN: N	DID TOBACCO USE CONTRIBUTE TO C		YES 🛛 NO 🗆	UNCERTAIN	<u>- </u>		1 YES 2 NO			
N: The law ficate has I State Dept Item 23	SICIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF	DEATH (Check only one)							
ICIAN: ertifica the St	IYSI	1 YES 2 NO 1 Inpatient 2	XER/Outpatient: 3 □ C		e 5 KRasidence 6						
this with	ВУ РНУ		Day, Year)		URY AT PRK?	28d. OESCRIBE HOW I	NJURY OCCURED				
TTENO! TTOR: A after da	ED	3 Suicide 6 Could not be building defermined	OF INJURY — At home, 1 g, etc. (Specify)	term, street, tectory, affici		261. LOCATION (Street a City or Town, State)	and Number or Rural	Route Number,			
	MPLET	29e. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best	ol my knowledge, death o	occurred at the time, date	and place, and due to	the cause(a) and mer	nner as stated.				
HOSPITAL FUNERAL WITHIN 72 ITANT: H	COM	one) 2 MEDICAL EXAMINER: On the basis of						(a) and manner as stated.			
TO THE HOSPI TO THE FUNER be filed within	BE	296. SIGNATURE AND TITLE OF FEMTIFIER	wV		D326		29d. DATE SIGNE	D (Month, Day, Year)			
0=	5	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CA	LEO KER	(Type, Print) ILWONTKIN		•	LT 212/	4			
		31. DATE FILED (Month, Day, Year) 32, REGISTI	RAR'S SIGNATURE			7 100	21-0				
		OCT 2 7 1995 John S	hydror Radal	(

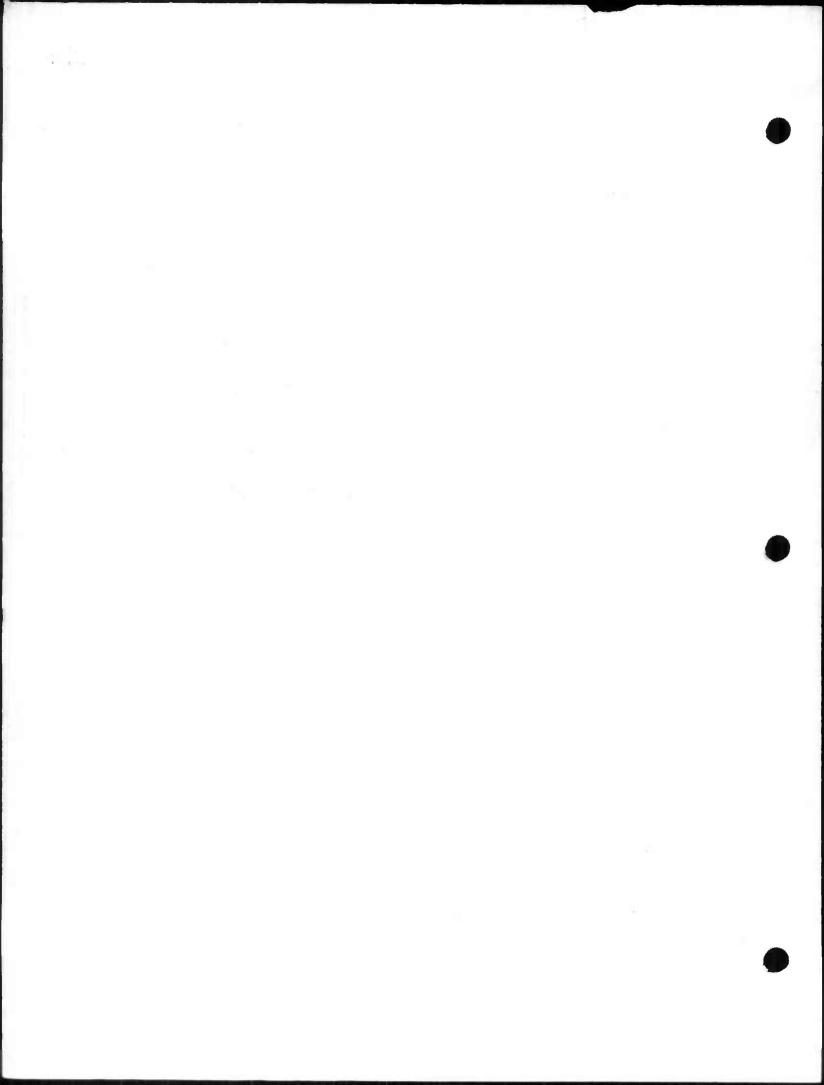
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AT	ECI	Sa	E
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hosp	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: It Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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31. DATE FILEO (Month, Day, Year)

OCT 2 7 1995

32 REGISTRAR'S SIGNATURE

	FOR STATE REGISTRAR	STATE OF I	MARYLAND /	DEPAR ERTIF					MENTAL	HYGIEN	E					
	DECEDENT'S NAME (First, Middle, Lest) Mary	ELIZABE	ТН			Mili	ch	.~		OF DEATH	3. TIME OF DEATN 5:00 A M					
	4. SOCIAL SECURITY NUMBER 577-07-8155	5. SEX 1 M 2 XXF	6. AGE (In yrs. las	t birthday) YRS.	IF UNDER	DAYS	IF UNDE	24 HRS. MIN.	7 DATE (NE BIRTH		6. BIRTNPLACE (State or Foreign MARYLAND				
OR	9e. FACILITY NAME (If not Institution, give st 10445 MARK DRIVE		9b. CITY		R LOCAT	ON OF DE			9c. COUNTY OF DEATH CHARLES							
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY MARYLAND C	10c. CIT	Y, TOWN C		ION DORF						10d. INSIDE CITY LIMITS?					
1	104. STREET AND NUMBER 10445 MARK DRIVE				101. ZIP CODE 109. CITIZEN OF WHAT COUNTRY? 20601 UNITED STATES											
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 Married 3 N Widowed 4 Divorced	IMED NO		If yes, sp	ocity Cub	OF NISPAI	NIC ORIGIN	? (Specify Yes lican, etc.)		14. RACI Blac	E — American Indian, k, White, etc.					
COMPLETED	(Specify only highest grade completed) (Give				USUAL O work done se retired.) USEW	during mo		ing	16b.	OWN	HOM					
BE COM	17. FATNER'S NAME (First, Middle, Last) WILLIAM SIMMS								4	fiddle, Malden	,	(Y				
TO B	19a. INFORMANT'S NAME (Type/Print) MRS. JACKIE R. HO	FFMAN								MARY			01			
	206 METNOD OF DISPOSITION 1 A Burlel 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) 206 PLACE AND DATE OF DISPOSITION (Name of Competition o															
	MGB MARK G. BROHAWN MOOO53 THE HUNTT FUNERAL HOME, INC. P.O.BOX 156, WALDORF, MARYLAND 20604															
	23. PART I. Enter the diseasea, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, ahock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): Approximate interval Between Onset and Daeth Cardiac Cardia															
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. OUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF):															
PHYSICIAN: MEDICAL CI	PART II. Other significant condition	nderiyin	g cause				ORMEO? AMAILABL COMPLET DF DEATI		D. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH							
AN: N	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN															
SICI	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 28. PLACE OF DEATH (Check only one) OTHER: 1 Inpetient 2 ER/Outpetlent 3 DOA 4 Nursing Nome 5 Residence 8 Other (Specify)															
ВУ РНУ	27. MANNER OF DEATN 1 Natural 5 Pending 2 Accident Investigation	ME OF JURY M		URY AT ORK? YES 2	□ NO	26d. DES	DESCRIBE NOW INJURY OCCURED									
0	3 Sulcide 6 Could not be determined 28a. PLACE OF INJURY — At home, farm, street, fectory, office building, atc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)										Route Number,					
COMPLETE	29a. CERTIFIER (Check only one) 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
BE	296. SIGNATURE AND TITLE OF CERTIFIER 296. LICENSE N DICE								MBER 23-7		29d. DA	re signed	Month, pay, Year) 24 (95			
0	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Typo. Print) Nirmaladevi Gurusamy, MD. 11345 Pembrooke Square Suite 104 Waldorf, Maryland 20603															



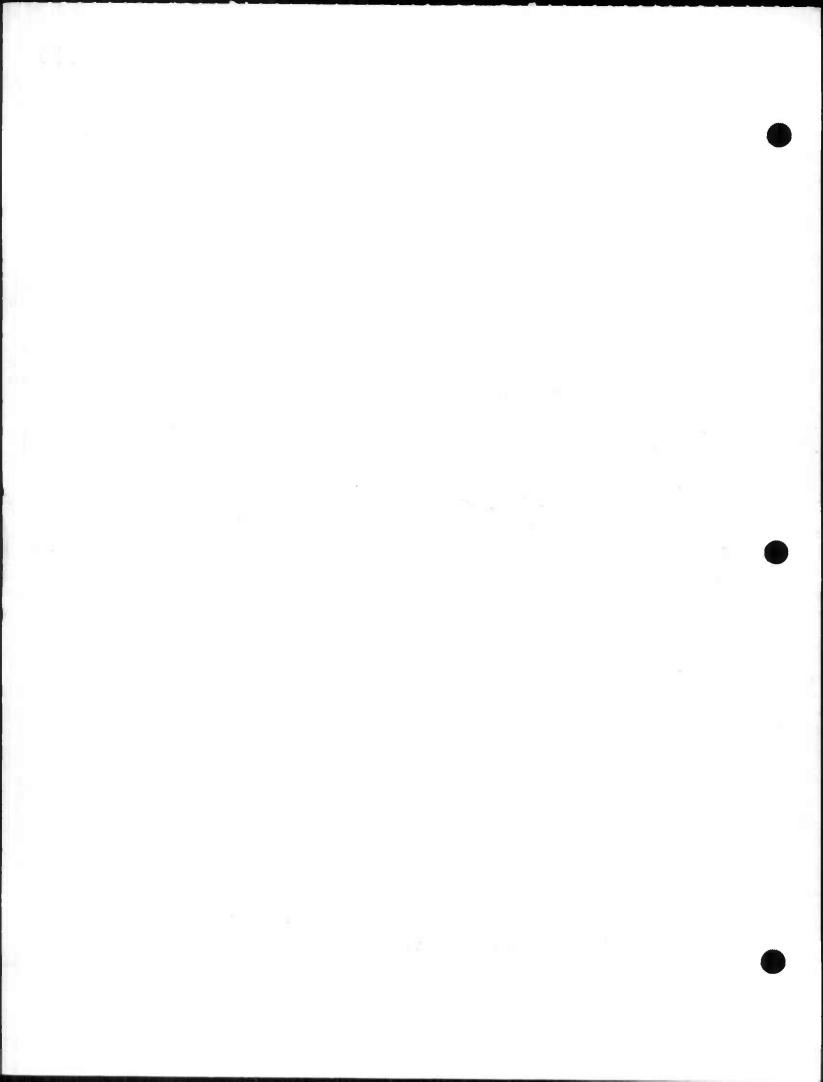
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunkal-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunkal, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	FOR 1 - STATE REGISTRAR	STATE OF MARYLA	ND / DEPARTI			MENTAL	HYGIEN	E					
	1. DECEDENT'S NAME (First, Middle, Last)	MADIE MEM	7			MONTH	OF DEATH	100E	AR	TIME OF DEATH			
		MARIE MET		F UNDER 1 YEAR	IF UNDER 24 HRS.	_	• LO,			:47 P. M			
1		□ M 2 💢 F 6. AGE (III)		ONTHS DAYS	HOURS MIN.	(Month	Day, Year)		Country)	CE (State or Poreign			
_	9a. FACILITY NAME (# not institution, give street	and number)	9	b. CITY, TOWN O	R LOCATION OF DE	ATH		9c. COUNTY	OF DEAT	н			
DIRECTOR	At Home- 2029	1 Nantico	re			Wic	omi	CO					
IRE	Md. Wico	mi a a	10c. CITY,	TOWN DR LOCAT	27.01			4	I. INSIDE CITY				
	MICO 10a. STREET AND NUMBER	mico		Biva1	. V E			10a. CITIZEN		XYES 2 ND			
RA	20291 Nantico	1	21814										
FUNERAL		U.S. ARMED	13 WAS DEC	ENDENT OF HISPAN	IIC DOIGIN	7 (Specify Vec		A.	American Indian.				
	1 Never Merried 2 Married	FDRCES? 1 YES	ZX NO	2X NO If yes, specify Cuban, Mexicen, Puarto Ricen, etc.)						White			
BY	3 Widowed 4 Divorced	I IEG, GIVE VANI ST, SM	123	1 160	z (Zisto opecii)				WIIICE				
COMPLETED	15. DECEDENT'S EDUCATI (Specify only highest grade com-	IDN noteted)	16a. DECEDENT'S US	rk done durina mo	N st of working	16b.							
		College (1-4 or 5+)	ille. Do NDT use i	retired.)									
MP	7	0	Home	Maker			wn Ho						
8	17. FATHER'S NAME (First, Middle, Last)	1 1 -			18. MOTHER'S NA								
BE	J. Biship Mes	SICK	1					ddish					
2	19a. INFORMANT'S NAME (Type/Print)				nd Number or Rural i					01014			
	James F. Metz				icoke 1								
	20e. METHOD OF DISPOSITION 1 💢 Buriel 2 🗆 Cremetion 3 🗆 Removal 4 🗆 Donation 8 🗆 Other (Specify)		PLACE AND DATE OF PLACE OF COMMENT OF COMMEN	Cemet	ery		18 Bi	ivalve, Md.					
	22. NAME AND ADDRESS OF FACILITY Messick Funeral Home, P.O. Box 61 Bivalve, Maryland 21814												
	22. PART I. Enter the diseases, or com			t enter the mo	de of dying, auc	h aa card	liac or reapi	ratory screat		Approximata Interval Between			
	IMMEDIATE CAUSE (Final disease or condition resulting in death)									Onset, and Dasth			
	disease or condition resulting in death) Due to (DR AS A CONSEDUENCE OF):												
CERTIFICATION	Sequentially list conditions, If any, leading to immediate DUE TO (DR AS A CONSEQUENCE DF):												
3	cause. Enter UNDERLYING CAUSE (Disease or injury												
H	that initiated events resulting in death) LAST	DUE TO (DR AS A	CONSEQUENCE OF):										
H	d												
AL C	PART II. Other significant conditions of	contributing to death bu	ut not resulting in	the underlyin	g cause given in	Part I.	24a. WAS AN			RE AUTOPSY FINDINGS			
2							PERFOR		CC	AILABLE PRIOR TO MPLETION DF CAUSE DEATH?			
										YES 2 NO			
3	DID TOBACCO USE CONTRIB	SUTE TO CAUSE OF	F DEATH YES	□ NO □	UNCERTAI	N 🗆							
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE DF DEATH										
Sic		IOSPITAL: Inpetient 2 ER/Output		OTHER: Nursing Hor	ne 5 Sesidence	6 🗆 Othe	r (Specify)						
Ě	27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME INJU	OF 28c. INJ	IURY AT	28d. DES	CRIBE HOW	NJURY OCCUR	ED				
ВУ	1 Natural 5 Pending 2 Accident Investigation	1 Neture 5 Pending											
	3 Suicide 8 Could not be 4 Homicide datarmined 26a. PLACE OF INJURY — At home, farm, street, factory, office City or Town, State) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									e Number,			
Ш	29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated.												
COMPLETED	(Check only one) 2 MEDICAL EXAMINER: Dn the besis of axemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and menner as stated.												
									ONED /gh	oven, gas, Years			
) BE	May han	111)			0306	93		> /	0/1	9/91			
5	30. NAME AND ADDRESS OF PERSON WHO C	OMPLETED CAUSE OF DE			0	-			1	7			
	STEPHEN C	RASHAW		060	Riversize	Dr	SAC	1318 WE	1 1	w.			
<	OCT 1 9 1995	JE REGISTRAR'S SIGN	Rardall										



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Z4 hours after death. Page 6 may be retained by the hospital or requires that the strending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH BEG NO

							TOM	- 01			H	EG. NO.			
		1. DECEDENT'S NAME (First	t, Middle, Last)								2. DATE OF E				3. TIME OF DEATH
		Raymo	nd Al	bert Ma	v. Jr	Jr.					MONTH DAY YEAR				7 004
		4. SOCIAL SECURITY NUMBER		5. SEX					October 30 1995				7:39A M		
- 1							MONTHS	7	HOURS	R 24 HRS.	7. DATE OF B (Month, Day	(PCTH (, Ybar)		6. BIRTHE Country	PLACE (State or Foreign
		020-07-3412		1 💢 M 2 🗆 F	71	YRS.		J	noons	Milita.	Aug 9 1924				achusetts
		9s. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF D													
_	Œ	Anne Arund	al Mad	ion! Con	tor	Annapolis									
- 1	СТОВ	RESIDENCE OF DEC	CEDENT	TCaT Cell	Lei				ишар	0115				Ann	e Arundel
	W I	10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION													
	E	100	10											10d. INSIDE CITY LIMITS?	
	ā			Arundel		Annapolis					1 TES 2 X NO				
	AL	100. STREET AND NUMBER						10	f. ZIP CODI	E			10g. CIT	ZEN OF W	HAT COUNTRY?
	E	1528 Circl	e Driv	е					2	1401			Un	ited	States
	FU	11. MARITAL STATUS		12. WAS DECEOER	IT EVER IN U.S.	IN U.S. ARMED 13. WAS DECENOENT OF HISPANIC O									
- 1		1 Never Married 2 X		2 NO If yes, specify Cuben, Mexican, P			n, Puerto Rican	n, Puerto Rican, atc.) Biack			- American Indian, White, atc.				
- 1	B									Specify	specify: White				
- 1	E .	42 OFFERFULIO FRUIDATION											VIIIICO		
- 1	2	15. OECEDENT'S EDUCATION (Specify only highest grade completed) 16a. OECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working) 16b. KIND OF BUSINESS/INDUSTRY													
	iw	Elementery/Secondary (0-12) College (1-4 or 5+)													
	<u>a</u>			2	Sa	ales R	s Representative					Silver Salesman			
and a	COMPLET	17. FATHER'S NAME (First, M	liddle, Last)			18. MOTHER'S NAME						-			
at	E C	Raymond A.	May												
be notified at once.	8				r	401 100000				IVIB	ry A.G.	. iVIQ	ore		
E I	2	19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zig.													
		Emily S. M	ay			1528	Circ	le D	rive	Ann	apolis.	, Mai	rylar	nd 21	401
2		20a, METHOD OF OISPOSITI			20b. PLA	CEANDDATE	OF DISPO	SITION /A/	ame of		DATE	200 1.00	MOITA	City or Tow	- Panta
Ĕ		4 Donation 5 Other		oval from State	cemetery,	crematory or c	ther place,	emat	orv	11/3	/05	Bro	ntun	A bo	foruland
5	- 1	ZIVE ZINOOTH OF GRACEOTY TITOUTS TELEVISION AND VISION													
副	- 1	22. NAME AND ADDRESS OF FACILITY John M. Taylor Funeral Hom													neral Home
8	- 1	Tomalal	×1.	1 7/1	1/		114	17 Di	ike o	f GI	oucest	er S	t. A	nnanc	olis, MD
8		23. PART I. Enter the di	iseasea or c	omplications the	t caused the	death Do	not ante	- 40	ola ad stud					mape	
or other traumatic event, the medical examiner must	- 1	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ahock, or heart failure. List only one cause on each line. Approximate interval Betwee													
		IMMEDIATE CAUSE (Final												Onset and Death	
£	disease or condition											1 11 0			
9		DUE TO (OR AS A CONSEQUENCE OF):													
5	_ 1	DUE TO (OR AS A CONSEQUENCE OF):													
흥	CERTIFICATION	Sequentially list conditions,													
통	Ē	If any, leading to immediate cause. Enter UNDERLYING													
늘	2	CAUSE (Disease or Inju		1											
<u>ا</u> ةِ	쁘ㅣ	that initiated events		DUE TO	(OR AS A CON	SEOUENCE O	F):								
6	도	resulting in death) LAST													
2	ខ														
ows any Injury.	4	PART ii. Other algnifica	nt condition	a contributing to	death but no	ot resulting	in the u	nderiyin	g cause g	given in	Part I. 24a.	WAS AN			WERE AUTOPSY FINDINGS
au A	EDICAL									1	PERFORMED?			AVAILABLE PRIOR TO COMPLETION OF CAUSE	
2											[1]	YES 2	KI NO		OF DEATH?
ž.	Σ∥	DID FOR LOCAL													1 TES 2 NO
23	SICIAN:	DID TOBACCO U	SE CONTI	RIBUTE TO CA	USE OF D	EATH Y	S	NO [UNC	ERTAIN	1X				
E	<u> </u>	25. WAS CASE REFERRED TO EXAMINER?	O MEDICAL		28. PI	LACE OF DEA	TH (Check	only one)							
Hem	š	1 YES 2 X NO		HOSPITAL:	XER/Outpations	3 DO4	OTHE:			aldere-	6 Other (Spe	al6.0			
0	PH	27. MANNER OF DEATH		28a. DATE OF		28b. TIM				sidence					
Is marked,	۵		Pending	(Month, D			IURY		PRK?		28d. OEŞCRIB	E HOW IN	JURY OC	JURED	
Jen :	à		Investigation				М	1 🗆 '	YES 2	NO					
9	o 1	3 Suicide 8 .	Could not be	28a, PLACE O	F INJURY — At etc. (Specify)	home, ferm,	street, fec	tory, offic	•		28f. LOCATION	(Street a	nd Number	or Rural Ro	ute Number,
00	w n		determined	Suraning,	- in (abouty)						City or Tow	rri, State)			
The T	W I	290, CERTIFIER													
	9 1	(Check only		CIAN: To the beat of											
	COMPLET	2 MEDI	CAL EXAMINE	R: On the basis of s	xemination and/	or investigation	on, In my o	opinion, d	eath occur	ed at the	time, date and p	placa, and	due to th	e cause(a)	and manner se stated.
		29b. SIGNATURE AND TITLE	OF CERTIFIER						29c ICE	NSE MIM	IRER	T	204 047	E SIGNED /	Month Day March
2	ᇤ	C lass			The state of the s					OATE SIGNED (Month, Day, Year)					
≥	၉	Ch dele							D2	46462	۷		- 00	tope	r 30 1995
- ['		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)													
		Alan Weiss	, M.D.	139 Old	Solomo	ons Is	land	Roa	d Anr	napo	lis. M	214	101 (410-	224-2222)
	1	31. DATE FILED WORTH DAY	(bar) 100F	32. MEGISTRA	AUCLEAN	Б				-					
		0013.	1333	julia d	andrex-6	broall									
	18			16 /											

DIVISION OF VITAL RECORDS, P.O. BOX 68760

-	FOR STATE REGISTRAR	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL CERTIFICATE OF DEATH	HYGIENE BEG. NO.

	REGISTRAR		CERTI	FICA	ATE O	F DEATH		REG. NO).		
	1. DECEDENT'S NAME (First, Middle, Lest) BURAL CATHERINE						2. DAT MON 1 1	e of death th 01	199	YEAR	7:15 am
	4. SOCIAL SECURITY NUMBER 216-07-7063	5. SEX 6.	AGE (In yrs. lest birthde)) IF I	INDER 1 YEA		7 DATE	E OF BIRTH	1.	BIRTHPL	LACE (Stere or Foreign
E	90. FACILITY NAME (If not institution, give 1141 MEMORIAL DR		1000	9b.	OAKI	N OR LOCATION OF D		1, 1	9c. COUNTY		ATH
CTOR	RESIDENCE OF DECEDENT] GAR	KEII	L
DIREC		RAMENTO			WN OR LO						Od. INSIDE CITY LIMITS? X YES 2 NO
FUNERAL	100. STREET AND NUMBER 7259 FARM DALE WA	Y				10f. ZIP CODE 95831			10g. CITIZEI		AT COUNTRY?
BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT E FORCES? 1 I IF YES, GIVE WAR	YES 2 NO		If yes,	DECENDENT OF HISPA , specify Cuben, Maxic YES 2 NO Speci	en, Puerto	N? (Specify Ye Ricen, etc.)	a or No — 14		- American Indian, White, etc. WHITE
ED	15. DECEDENT'S EDI (Specify only highest grad	JCATION e completed)	16a. DECEDENT	'S USU	AL OCCUP	ATION most of working	16	b. KIND OF BU	ISINESS/INDUS	TRY	
COMPLET	Elementary/Secondary (0-12)	College (1-4 or 5+)	TAX CI	use reti	red.)	most or working		STATE	GOVERN	MENI	r
ш	17. FATHER'S NAME (First, Middle, Lest) CARL WELLINGTON	FRAZEE				18. MOTHER'S NA EMMA	AME (First, MARG		Surname)		
10 18	190. INFORMANT'S NAME (Type/Print) TERESA MADEIRA		19b. MAILIF 7259	FA	RESS (Stree	ALE WAY			vn, State, Zip Co		5831
	20a METHOD OF DISPOSITION 1 \(\) Burlel 2 \(\) Cremation 3 \(\) Ren 4 \(\) Donation 5 \(\) Other (Specify)	noval from State	20b. PLACE AND DAT	Sher	SPOSITION CEMET	(Name of ERY	11/		CRAMENT		
	21. SIGNATURE OF JUNETIAL SERVICE LI	Deut	M00167			ST FUNERA			O. BO		
	23. PART I. Enter the diseases, or shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition	complications that co List only one cause	sused the death. Do on each line.	not e	nter the	mode of dying, suc	ch aa cer	disc or resp	iratory arrea	t,	Approximats Interval Between Onset and Death
	resulting in desth)	S. Ventrica	ular Arrhy		ia,	Acute					Sudden
202	Sequentially list conditions, if sny, leading to immediate course. Enter UNDERLYING DUE TO (OR AS A CONSCOUENCE OF): Anthony is an allowed by the conditions of the conditio										
CERTIFICATION	CAUSE (Disease or Injury that Initiated events resulting in death) LAST CATERIOS CLEROTIC Cardio-VaSular Disease Unknown DUE TO (OR AS A CONSEQUENCE OF):							Unknown			
	PART II. Other significant condition	ns contributing to de	sth but not resulting	in the	e underly	ing ceuse given in	Part i.	24s. WAS AN			PERE AUTOPSY FINDINGS
FDICAL								1 TYES		CI	MILABLE PRIOR TO OMPLETION OF CAUSE of DEATH?
AN: M	DID TOBACCO USE CONT	RIBUTE TO CAUS		_	11		Ν□				YES 2 NO
PHYSICIAN	EXAMINER? 1 1 YES 2 NO	HOSPITAL:	26. PLACE OF DE	OT	HER:	lome 5)(] Residence	e [] 04	an (Constitute			
	27. MANNER OF DEATH 1- Vinetural 5 Pending Investigation	28a. DATE OF INJ (Month, Day,	JURY 28b, TI		28c.	INJURY AT WORK?			INJURY OCCUR	IED	
red BY	2 Accident investigation 3 Suicide 8 Could not be 4 Homicide determined	28s. PLACE OF IN building, etc.	IJURY — At home, farm . (Specify)	, street,	factory, or	ffice	26f. LOC City	CATION (Street or Town, State)	and Number or	Rural Rou	ite Number,
COMPLET		ICIAN: To the best of my									
BE CO	290. SIGNATURE AND TITLE OF CERTIFIE	ER: On the beals of axam	ination and/or investigat	ion, in	my opinior	29c. LICENSE NU		e and place, ar			forth, Day, Year)
TO B	30 NAME AND ADDRESS OF PERSON WI	O COMPLETED SAUSE O	OF DEATH (ITEM 27) (TYPE	2 D	-	D 056.			Nov	embe	r 1, 1995
	Herbert H. Leigh	nton, M,D.,	, 502 E. O	ak	Stre	et, Oakla	nd, l	MD 21	550		
5	31. DATE FILED (Month, Day, Year) NOV 0 1 1995	32. REGISTRAR'S	SIGNATURE								
	The state of the s	//									

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Z4 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE RUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	TATE OF MARYLAND / C	DEPARTMENT OF H	EALTH AND MI	ENTAL HYGIENE REG. NO.		
10	1. DECEDENT'S NAME (First, Middle, Last)				DATE OF DEATH		3. TIME OF DEATH
0	Lucas Benjamin	MCCLURE			October 24	1995	11:20 P M
	4. SOCIAL SECURITY NUMBER 5. SI	EX 6. AGE (In yrs. last b		IF UNDER 24 HRS. 7	. DATE OF BIRTH	8. BIRTI	IPLACE (State or Foreign
	none	M 2 🗆 F	YRS. MONTHS DAYS	HOURS MIN.	(Month, Day, Year) Oct. 15, 19	995 Ma	rvland
	9a. FACILITY NAME (If not institution, give street ar	nd number)	9b. CITY, TOWN C	R LOCATION OF DEAT		COUNTY OF	
DIRECTOR	Franklin Square Hos	spital	Ros	sville		Baltimo	re
E	10a. STATE 10b. COUNTY		10c. CITY, TOWN OR LOCAT	ION			10d. INSIDE CITY
٥	Maryland Harfo	ord	Bel Air				1 X YES 2 NO
FUNERAL	10e. STREET AND NUMBER		101	ZIP CODE		log. CITIZEN OF	WHAT COUNTRY?
N.	739 Orley Place			21014		USA	
	1X Never Married 2 Married	MAS DECEDENT EVER IN U.S. ARME FORCES? 1 TYES 2 TO NO		ENDENT OF HISPANIC scify Cuban, Mexicen, I	ORIGIN? (Specify Yes or Puerto Rican, atc.)	No- 14. RACI	E — American Indian, k, White, atc.
B	3 Widowed 4 Divorced	F YES, GIVE WAR OR DATES	1 🗆 YES	2X NO Specify:		Spec	
8	15. DECEDENT'S EDUCATION	N 16e. DECE	DENT'S USUAL OCCUPATION	DN .	16b. KIND OF BUSIN	ESS/INDUSTRY	WIIICE
ET.	(Specify only highest grade complete Elementary/Secondary (0-12) Coll		kind of work done during mo o NOT use retired.)	st of working	4.2		
MPL	n/a						
COMPLETED	17. FATHER'S NAME (First, Middle, Last)			16. MOTHER'S NAME	(First, Middle, Maiden Su	mame)	
BE		Clure			n Gloria	Lucas	
2	19a. INFORMANT'S NAME (Type/Print)		MAILING ADDRESS (Street a				
	Richard W. McClure		880 Hampton			77	30548
1	1 X Burial 2 Cremetion 3 X Removal fr	rom State cemetery, crema	D DATE OF DISPOSITION (Na Mory or other place)			TION — City or To	
1	21. SIGNATURE OF FUNERAL SERVICE LICENSES		al Park	10-25 D ADDRESS OF FACIL	9-95 Gai	nesville	e, Ga.
	· Steple al	dinel.	Howan	d K. McCor	mas III Fu	neral H	ome, P.A.
-	22 DARY I Serve the diseases of serve	yuguy	1 1317	Cokesbury	Rd. Abin	adon. Mo	d. 21009
	23. PART I. Enter the diseases, or compl shock, or heart failure. List o	inly one ceuse on each line.	n. Do not enter the mo	de of dying, such a	na cardiac or reapirat	lory arrest,	Approximata interval Between
	iMMEDIATE CAUSE (Final disease or condition	spacie la	2				Onset and Death
	resulting in death) a	DUE TO (OR AS/A DONSEOU	ENCE OF:				days
z	.	Oxtreme	DARIN	aturat	23		d
5	Sequentielly list conditions, if any, leading to immediate	DUE TO OR AS A CONSEQUE	ENCE ON:		1		ays
2	CAUSE (Disease or injury		V				
	that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEQUE	ENCE OF):				
CERTIFICATION	d						
AL	PART II. Other aignificent conditions con	tributing to death but not res	ulting in the underlying	cause given in Pa	rt i. 24a. WAS AN AU		WERE AUTOPSY FINDINGS
						NO	AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
MEDIC							1 YES 2 NO
ä	DID TOBACCO USE CONTRIBU	TE TO CAUSE OF DEATH	YES NO	UNCERTAIN			
PHYSICIAN:		26. PLACE (OF DEATH (Check only one) OTHER:				
IYS		Inpatient 2 ER/Outpatient 3	DOA 4 Nursing Hom	5 Residence 8			
	Natural 5 Panding	28a. DATE OF INJURY (Month, Day, Year)		RK7	ad. DESCRIBE HOW INJU	JRY OCCURED	
ВУ	Accident Investigation	28e. PLACE OF INJURY — At home		ES 2 NO	Bf. LOCATION (Street and	Mumber of Dent 6	
E	4 Homicide determined	building, etc. (Specify)	, and the state of		City or Town, State)	NUMBER OF NUMBER	Number,
LET	29a. CERTIFIER 1 CERTIFYING PHYSICIAN: 1	To the best of my knowledge, death	occurred at the time date	and place and during		. codini	
COMPL		the besis of examination and/or invi) and manner as stated.
	29b. SIGNATURE AND TITLE OF CHATIFIER	YLIBE COC	F 0 - 1	29c. LICENSE NUMBE			(Month, Bay, Year)
) BE	seouteau	Newastol	09	D 42595		10/2	4/95
70	30. NAME AND ADDRESS OF PERSON WHO COM	PLETED CAUSE OF DEATH (ITEM 2	17 (3/po. prot)		/ / /		1
	Han Bedric	K Wan	HIA 9	hare H	ospital		
	31. DATE FILED (Marth, Day, Sher)	ALLA SAUGUAN RANG	0	1			
	7 70 1333	para converse Rando	ells				

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within, and hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

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1	-	FOR STATE REGISTR	AR	
i	1. DI	ECEDENT'S	NAME	(Fir

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR	ERTIFICATE C	OF DEATH	REG. NO				
	1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH		3. TIME OF DEATH		
	George Kenneth Moss			October 22		7:40 p M		
1	George Kenneth Moss 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lea)	t birthday) IF UNDER 1 YE		7. DATE OF BIRTH		THPLACE (State or Foreign		
	440-20-0256 1 ☑ M 2 □ F 70	YRS. MONTHS DAY	YS HOURS MIN.	(Month, Day, Year)	Cour	ntry)		
	9a. FACILITY NAME (If not institution, give street and number)	9h CITY TOY	WN OR LOCATION OF DE	Nov. 23,	9c. COUNTY OF			
œ				AIT				
5	2310 Titan Terrace	Havre	de Grace		Harfo	ord		
DIRECTOR	10e. STATE 10b. COUNTY	10c. CITY, TOWN OR LO	OCATION			10d, INSIDE CITY		
片	Maryland Harford	Hayrro	de Grace			LIMITS?		
	10e. STREET AND NUMBER	1 IMVIE	10f. ZIP CODE		10a CITIZEN OF	WHAT COUNTRY?		
FUNERAL	2310 Titan Terrace		21078					
Ž	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARI	MED 12 MMC	DECENDENT OF HISPAN	10.00000000000	U.S.			
	1 Never Married 2 Married FORCES? 1 X YES 2 N	IO If yes	i, specify Cuban, Maxican	n, Puerto Rican, etc.)	or No- 14, RAC	CE — American Indian, ck, White, etc.		
BY	3 Widowed 4 Divorced IF YES, OIVE WAR OR DATES WW II & Korea	10	YES 2 NO Specify.			om: nite		
G.	15. DECEDENT'S EDUCATION 16a DEC	CEDENT'S USUAL OCCUP	PATION	165 KIND OF BUIL	SINESS/INDUSTRY	irce		
<u> </u>	(Speciny only nignest grade completed) (Gif	ive kind of work done during Do NOT use retired.)	most of working	Total Kills of Box	SINE SS/INDOSTAT			
귑		S. Army		Milita	237			
COMPLETED	17. FATHER'S NAME (First, Middle, Last)	D. TELLY	18 MOTHED'S NAS	ME (First, Middle, Maiden				
0	George Milton Moss			May Haywo				
BE		. MAILINO ADDRESS (Str						
2						21070		
= 1		2310 Titan AND DATE OF DISPOSITION		DATE 20c. LO				
. 0		matory or other place). rd Memoria.	Cardone	10/26 Abo	callon — city or 1	fown, State		
. 1	21. SIGNATURE OF FUNERAL SERVICE LICENSEE		E AND ADDRESS OF FAC		rueen, P	aryland		
	M. O. D. H.	Tari	ring-Cargo	Funeral H	lome, P.A	١.		
	Mary K. N. Herranni	Abei	rdeen, Mary	vland 210	01-3399			
	23. PART i. Enter the diseases, or complications that caused the dec shock, or heart fellure. List only one cause on each line.	eth. Do not entar the	mods of dying, auch	an cardiac or respi	retory srrest,	Approximats		
	IMMEDIATE CAUSE (Fine)					intarval Between Onset and Death		
	disease or condition							
	resulting in death) DUE TO (OR AS A CONSEO	DUENCE OF):	CONL			12 -70-413		
7								
CERTIFICATION	Sequentially list conditions, if any, isading to immediate	UENCE OF):						
8	cause. Enter UNDERLYING							
Ē	CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEO	UENCE OF):						
E	resulting in death) LAST							
	PART II Osharala Wasan Mila							
MEDICAL	PART II. Other significant conditions contributing to deeth but not re		ying cause given in F	Part i. 24s. WAS AN PERFOR		b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO		
Did	Condumy poting of string of	SING		1 YES 2	No	COMPLETION DF CAUSE OF DEATH?		
ME						1 YES 2 NO		
ä	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEAT	TH YES NO	☐ UNCERTAIN					
CIA		E OF DEATH (Check only o	one)					
SI	1 YES 2 NO HOSPITAL: 1 Input lent 2 ER/Outpstient 3	☐ DOA 4 ☐ Nursing i	tome 5 🗆 Rasidenca 6	Other (Specify)				
PHYSICIAN:	27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Dey, Year)	28b. TIME OF 28c.	INJURY AT	28d. DESCRIBE HOW IF	NJURY OCCURED			
BY F	1 Metural 5 Pending	INJURY M 1 [WORK7 YES 2 NO					
	3 Suicide 28s. PLACE OF INJURY — At hon	ma, fárm, street, factory, c	office	28f. LOCATION (Street a	nd Number or Rural	Route Number.		
COMPLETED	4 Homicide determined building, etc. (Specify)			City or Town, State)				
2	290. CERTIFIER 1 CERTIFYING PHYSICIAN: To the heat of my knowledge to			my man — man my				
M M	(Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or in							
8		Trougation, in my opinion			due to the cause(a) end manner as stated.		
H	29b. SIGNATURE AND TITLE OF CERTIFIER		29c. LICENSE NUMI			O (Month, Day, Year)		
12.0			133088		10-23			
	Berton Balan		7 00 00		3	-75-		
TO .	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM	1 27) (Type, Print)			-	-75-		
	1321 NIVESIDE PROP SUIT A BERCH	1/ 10 2/0			3	-75-		
	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 1321 NIVES OF DEATH (ITEM 1321 NIVES) A STUCKY 31. DATE FILED (MOTH), AND MOST 1995	1/ 10 2/0						

Pages 1, 2, 3

permit.

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-trans		
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led wit	omple	al, cre	aven
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uires t	Signe	Health	Park 2
aw req	s been	ept. of	3 shr
The	cate ha	state D	item ;
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ENDIN	DR: Aft	fter de	8 is a
OR AT	CHEC	OUIS a	lem 2
PITAL	ERAL (11 27 h	THEM
E HOS	E FUN	d with	RTAN
5	HI OF	De file	IMPR

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. 95 33720 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 2010 Pm JEORGE HOMAS 4 SOCIAL SECURITY NUMBER 5 SEY 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTNPLACE (State or Foreign 7. DATE OF BIRTH April 23, 214-26-6292 17 M 2 | F 65 1930 North Carolina 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Harford Memorial Hospital Harford Havre de Grace RESIDENCE OF DECEDENT 10b. COUNT 10c. CITY TOWN OR LOCATION 10d. INSIDE CITY Maryland Harford Darlington 1 YES 2 X NO 10s. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 3931 Conowingo Road 21034 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—
If yee, specify Cuben, Mexican, Puerto Rican, stc.) 14. RACE - American Indian, Black, White, etc. 1 Never Married 2 Merried 1 TYES 2 NO Specify: BY Specify: 3 Wildowed 4 Divorced white ED 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only high ET Elementary/Secondary (0-12) College (1-4 or 5+) COMPL 9 Yard Man Auto Moving and Storage 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname) Thomas Jefferson McMillan Susie Miller BE Elizabeth 19e. INFORMANT'S NAME (Type/Print 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Ann M. McMillan 3931 Conowingo Road, Darlington, Maryland 21034 20e. METHOD OF DISPOSITION
1 Disposition | Burial | 2 | Cremation | 3 | Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State 1 ♥ Burlal 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify) or, crepatory of other placel Air, Maryland 10/23/95 Bel Air, Maryland 21. SIGNATURE OF FUNGRAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY McComas Funeral Home Omas 1317 Cokesbury Road, Abingdon, Md. 21009 23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feliure. Liet only one cause on each line. Interval Between IMMEDIATE CAUSE (Final Onset and Death disesse or condition resulting in death) Carcinoma ricenoma of lung
DUE TO (OR AS A CONSEQUENCE OF): with Months ongestine CERTIFICATION Sequentially list conditions, OUE TO (OR AS A CONSEQUENCE OF) If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF): cause. Enter UNDERLYING CAUSE (Disease or Injury that initisted events resulting in death) LAST Inemia PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PERFORMED? Prospe arcenome 1 TYES 2 NO 1 TES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 26. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL HOSPITAL: OTHER:
4 | Nursing Name 5 | Residence 6 | Other (Specify) 1 YES 2 NO 1 Inpetiant 2 ER/Outpetient 3 DOA 27. MANNER OF DEATH 28e. DATE OF INJURY 26b. TIME OF 28c. INJURY AT WORK? 28d, DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending 1 YES 2 NO BY 2 Accident Investigation 3 Sulcide 26e. PLACE OF INJURY — At home, ferm, atreet, factory, office building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be COMPLETED 4 Homicide 29e. CERTIFIER 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(a) end menner ee stated. 2 __ MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(e) and menner ee stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE 29d. DATE SIGNED (Month, Day, Year) Phy sicien 200

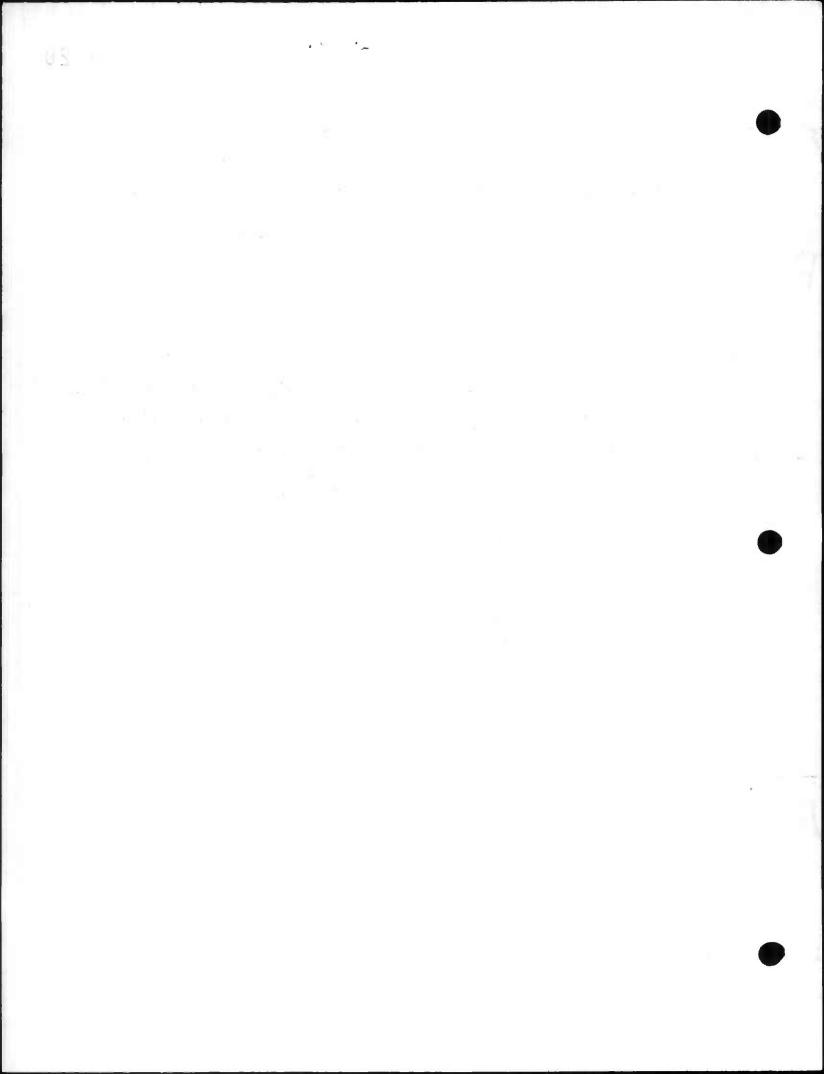
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30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

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	SPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 m	VERAL DIRECTOR: After this certificate has been signed by the attention of social and completely filled in by the funeral director.
		0
	S	3

	es 1, 2, 3 should		
IE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	E FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	lied within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	ANT: if item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
THE THE	TO THE	be filed	IMPOR

	FOR 1 - STATE REGISTRAR	STATE OF MARYLAND / I	DEPARTMENT OF REPARTMENT		MENTAL HYGIENE REG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH		3. TIME OF DEATN		
	Bernice	Ellen		Mohr	October 26,	1995 YEAR	9:03 P. M		
	4. SOCIAL SECURITY NUMBER 5	6. SEX 6. AGE (In yrs. last t	-		7. DATE OF BIRTH (Month, Day, Year)	8, BIRTHPI Country)	LACE (State or Foreign		
	577-20-0552 1 9a. FACILITY NAME (If not institution, give stree	M 2 K F 76	YRS.	DAYS HOURS MIN.	May 22 1919	Virg	ginia		
DIRECTOR	Physicians Memorial Ho		La P			Charle			
EC	10a. STATE 10b. COUNTY	T	10c. CITY, TOWN OR	LOCATION		1	IOd. INSIDE CITY		
	Maryland Charl	es	La Plat	a			YES 2 NO		
AL	10e. STREET AND NUMBER			101. ZIP CODE		10g. CITIZEN OF WH	AT COUNTRY?		
EB	709 Worcester Stre	et		20646		USA			
BY FUNERAL	11. MARITAL STATUS 1	2. WAS DECEDENT EVER IN U.S. ARM FDRCES? 1 ☐ YES 2 X NO IF YES, GIVE WAR OR DATES	If	S DECENDENT OF HISPA es, specify Cuban, Maxic YES 2 ND Speci		r No — 14. RACE - Black, Specify.	- American Indian, White, atc. White		
	15. DECEDENT'S EDUCAT	TION 16a. DECI	EDENT'S USUAL OCC	UPATION	16b. KIND OF BUSIN	(ESS/INDUSTRY	willte		
COMPLETED	(Specify only highest grade con Elamentary/Secondary (0-12)	mpleted) (Give life, D	kind of work done due to NOT use retired.)	ing most of working					
AP.	12		aitress		Resta	urant			
ő	17. FATHER'S NAME (First, Middle, Last)			18. MOTNER'S N.	AME (First, Middle, Maiden Su	rname)			
BE	Richard A. Floyd			Maude	E. Harvey				
TO B	19a. INFORMANT'S NAME (Type/Print)				Route Number, City or Town,				
F	Patricia Sturgis	71	09 Worces	ter Street	La Plata,	Maryland	20646		
	20a, METHOD OF DISPOSITION 1X Burlel 2 ☐ Cremation 3 ☐ Remove		ID DATE OF DISPOSIT	ON (Name of	DATE 20c. LOCA	TION — City or Tow	n, Stata		
	4 Donation S Donat (Specify)	Trini	tv Memori	al Gardens	10-28-95 W	aldorf, 1	MD D		
	21. SIGNATURE OF FUNERAL SERVICE LICEN	M0017:	3 J.H	. Eberwein	Mortuary				
	1 10 Has 4. 1	lesso.	118	55 holly L	ane #104 Wa	1dorf, MI	20601		
	23. PMO i. Enter the diseases, or cor	nplications that caused the deer	th. Do not enter the	e mode of dying, su	ch ss cardisc or respira	tory srrest,	Approximats		
	shock, or haert fallure. List only one ceuse on each line. IMMEDIATE CAUSE (Final Onset and Dayth								
	disease or condition resulting in dasth)								
		DUE TO (OR AS A CONSEQU	JENCE OF):	0 -1					
Z	Sequentielly list conditions,	adulin	Laker	any					
Ĕ	if any, leading to immediate cause. Enter UNDERLYING	DUE TO JOH AS A CONSEQU	HENCE OF	- + °	ilun				
CERTIFICATION	CAUSE (Disease or injury	DUE TO (UR AS A CONSEQU	WHEN OF	my fa	m				
Ē	thet initiated evente resulting in deeth) LAST	emples	2				i l		
SE		- //		:2					
A	PART II. Other significent conditions	contributing to death but not re-		erlying cause given in	Part i. 24s. WAS AN AI		VERE AUTOPSY FINDINGS		
5	preunanca	, respector	1 enul	Juciency	1 TES 2 5	2 110	COMPLETION OF CAUSE OF DEATH?		
MET	/			4			YES 2 ND		
ž	DID TOBACCO USE CONTRI	BUTE TO CAUSE OF DEAT	H YES 🗷 N	O UNCERTA	IN 🗆				
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26, PLACE	OTHER:	ly one)					
YSI	1 YES 2 ND	☑ Inpatient 2 ☐ ER/Outpatient 3 ☐		g Nome 5 🗆 Realdence	8 Other (Specify)				
PH	27. MANNER DF DEATN 1 ☑ Natural 5 ☐ Pending	28s. DATE DF INJURY (Month, Day, Year)	28b. TIME OF 2	Bc. INJURY AT WORK?	28d. DESCRIBE NOW INJ	JURY OCCURED			
В	1 (C Natural 5 Pending 2 Accident Investigation		М	1 YES 2 ND					
8	3 Suicida 8 Could not be	28a. PLACE DF INJURY — At hom building, atc. (Specify)	e, farm, street, factor	y, office	28t, LOCATION (Street and City or Town, State)	d Number or Rural Ro	ute Number,		
COMPLET	anal	AN: To the best of my knowledge, dest							
ő	2 MEDICAL EXAMINER:	On the basis of examination and/or in	vestigation, in my opi	nion, death occured at th	e time, data and place, and	dua to the cause(a)	and manner as stated.		
BE	204 STEMATURE AND TITCE OF CERTIFIER	tel tuno		29c. LICENSE NU		29d. DATE SIGNED	Month, Day, Year)		
10 8	Draw plet			D-08370		10/2	6/95		
É	30. NAME AND ADDRESS OF PERSON WHO								
	Paul E. Pritchett, Sr. 1	.18 La Grange Avenue	P.O. Box 1	317 Ia Plata	Maryland 20646	5			
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE							
	OCT 3 0 1995	Julia and more of the	Wall						

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DIVISION OF VITAL RECORDS, P.O. BOX 68760

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	Pages		
r attending physician.	FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2,		
after death. Page to may be retained by the hospital of	5 should be detached for		STANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
ge o may be	firector, page		r must be
eath. Fa	funeral d		camine
Aurs after d	in by the	r removal.	redical ex
xecuted within 24 ho	and completely filled	within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	latic event, the m
ath certificate be ex	ttending physician	tal Hygiene prior to	, or other traum
s that the de	ned by the a	afth and Men	any injury
law require	has been sig	Dept. of He	23 shows
SICIAN: The	certificate !	h the State	d, or item
NDING PHY	R: After this	or death with	is market
L OR ATTE	L DIRECTOF	? hours afte	item 28
HOSPITA	FUNERAL	within 72	ITANT: II

31. DATE FILED (Month, Day, Yber)

23 1995

32. REGISTRAR'S SIGNATURE Julia Davidson Revolate

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEPENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Linda Rohan McDermott MCDERMOT INDA 9:58 P M October 20, 1995 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year 5. SEX 6. AGE (In yrs. lest birthday) 8. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR IF UNDER 24 HRS. BHTHOM DAYS HOURS MIN 1 M 2 XF 55 YRS. 063-32-8538 July 31,1940 Massachusetts Sa. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c, COUNTY OF DEATH DIPECTOR Montgomery Manor Care-Potomac Potomac RESIDENCE OF DECEDENT 18c. CITY, TOWN OR LOCATION 10d, INSIDE CITY LIMITS? 1 YES 2 X NO Maryland Montgomery Darnestown FUNERAL 10e. STREET AND NUMBER 10f, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 16025 Bonniebank Terrace 20874 United States 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 XNO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yes, specify Cuban, Maxican, Puerto Rican, stc.) 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married IF YES, GIVE WAR OR DATES 1 YES 2 XNO Specify: Specify: BY 3 Widowed 4 X Divorcad White ETED 18e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade Elementary/Secondary (0-12) College (1-4 or 5+) COMPL 12 Secretary Accounting 17. FATHER'S NAME (First Middle Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Helen Gaska Francis Rohan BE 19s. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Pural Route Number, City or Town, State, Zip Code) 2 16025 Bonniebank Terrace, Darnestown, MD 20874 Patricia Rohan Fazio 20a. METHOD OF DISPOSITION
1 ☐ Burial 2X Cremation 3 ☐ Ramoval from State 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cremetory or other place) October 22, 19 Montgomery Crematorium, inc. 20c. LOCATION - City or Town, State 1995 Bethesda, Maryland 4 Donation 5 Other (Specify) 22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral 21. SKIMATURE OF FUNERAL SERVICE LICENSEE Home/Rockville, Inc., 300 W. Montgomery Ave Rockville, Maryland 20850-2805 Much M00348 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Approximate shock, or heart failure. List only one ceuse on each line. interval Batween Onset and Death IMMEDIATE CAUSE (Final disease or condition CANCER OVARIAN 16 yrs reaulting in death) DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS MEDICAL AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2X NO OF DEATH? 1 TYES 2X NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 26. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL **EXAMINER?** HOSPITAL: OTHER:

4 Nursing Home 5 Residence 8 Other (Specify) 1 - YES 27 NO Inpatiant 2 - ER/Outpetient 3 - DOA 28a. DATE OF INJURY (Month, Day, Year) 28c, INJURY AT WORK? 27. MANNER OF DEATH 26d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending 1 YES 2 NO BY Accident 28a. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) 281, LOCATION (Street and Number or Bural Route Number, City or Town, State) 3 Suicida ETED 8 Could not be 4 Homicide determined 29e. CERTIFIER
(Check only one)

20 MEDICAL EXAMINED: On the best of my knowledge, death occurred at the time, data and due to the cause(s) and menner as stated. COMPL 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and dua to the cause(a) and menner as stated. 296. SIGNATURE AND THE OF CERTIFIER 29c. LICENSE NUMBER 29d, DATE SIGNED (Month, Day, Year) BE TO THE De fied MPOR 021910 Sherer MD Ditober 21, 1995 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) B. Sherer mp wheaton Peter 20906 Ferrara Dr. mo 3947

Amended # 1, 1 - STATE REGISTRAR	10/26/9	5 JW, Mon STATE OF MA	tgomer ARYLAND C	y Cou DEPAR ERTIF	inty TMENT OF ICATE O	HEALTH ANI F DEATH	D MENTA	L HYGIEN REG. NO.	E		
1. DECEDENT'S NAME (Post ARG ARS	ET I	mo	RAN		2. DATE MONT	OF DEATH D	3 19	795	3. TIME OF DEATH
4. SOCIAL SECURITY NO. 577-16	5. SEX 6. AGE (In 173. In 12 1/2 1/2 1/2 1/2 1/2 1/2 1/2 1/2 1/2							7. DATE OF BIRTH (Month, Day, Year) APR 33,1910 Missouri			
Se. FACILITY NAME (# n	ot institution, give s	treet and number)			9b. CITY, TOW?	OR LOCATION OF	F DEATH		9c. COUP	NTY OF DI	EATH
	Holy Cross Hospital				Silv	er Sprin	ng		Mor	ntgor	nery
100. STATE	RESIDENCE OF DECEDENT 100. STATE 10b. COUNTY			10c. CIT	Y, TOWN OR LOC	ATION					10d. INSIDE CITY
Maryland	Mo	ntgomery		S	ilver S	pring					LIMITS? 1 YES 2 NO
						101. ZIP CODE			10g. CITI	ZEN OF W	HAT COUNTRY?
🖺 📗 2204 Denn	is Aven	ue				20902				USA	
3 Widowed 4	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced				If yes,	ECENDENT OF HIS specify Cuben, Mer ES 2 1 NO Sp	xican, Puerto		or No-	14. RACE Black Specif	- American Indien, , White, etc. y: White
(Specify Elementary/Seconds	(Specify only highest grade completed) (G				USUAL OCCUPA work done during se retired.)	TION most of working		b. KIND OF BUS			
12				Superv	visor			U.S. G		nment	
m George wa	rren Po	st				Henri	letta	Middle, Malden Paulin	e Wel		400
198. INFORMANT S NAM		ovendor				t end Number or Ru					20002
					Dennis Svenue, Silver Spring, MD 20902 TEOFDISPOSITION (Neme of DATE 200. LOCATION — City or Town, State						
1 🔀 Burlel 2 🗆 Crem					ther place)	tery 10	1/26/0	5 D	entwo		
21. SIONA URE OF FUN		CENSEE	120. 1	JANCO.		AND ADDRESS OF		J I DI	entwo	,000	FID
Dam	200	000	4		500		ity B1	vd.W.	Sil. 9	Spr.	Inc. MD 20901
IMMEDIATE CAUSE	r heart failure. (Final	List only one caus	e on each lin	ia.						reat,	Approximate interval Batween Onset and Daath
disease or condition resulting in deeth)										WEEKS	
if any, laading to in cause. Enter UNDEI CAUSE (Disease or that initiated events	Sequantially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):										
PART II. Other algni	M IA	na contributing to d	laeth but not	resulting	In the underly	ing ceuse given	in Part i.	24a. WAS AN PERFOI 1 YES 2	RMED?	24b	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
DID TOBACCO	USE CONT	RIBLITE TO CAL	ISE OF DE	ATH YE	S II NO	UNCERT	AIN FY	+			1 YES 2 NO
4	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)										
EXAMINER?		HOSPITAL:	ER/Outpatient	3 DOA	OTHER:	ome 5 🗆 Resider	nce 6 Oth	er (Specify)			
27. MANNER OF DEATH		26a. DATE OF II (Month, Day	NJURY	28b. TIN	E OF 28c.	INJURY AT WORK?		SCRIBE HOW	INJURY OC	CURED	
1 Natural 5	Pending Investigation	(Month, Da)	, reary	1		YES 2 NO					
3 Suicide 8	3 Suicide 8 Could not be 28s. PLACE OF INJURY — At home, farm, street, fectory, office building, etc. (Specify) 28s. PLACE OF INJURY — At home, farm, street, fectory, office City or lown. State)								Route Number,		
CONSUM ONLY		SICIAN: To the best of a									e) and menner se stated.
	-	0//			on, in my opinion			and place, di			
	11	1km	10			D 4	O 3	65	P C)C.T	(Month, Day, Year)
30. NAME AND ADDRESS PETER 19313	GEOR	HO COMPLETED CAUSE	OF DEATH (IT	TEM 27) (Type	308 S	SILVER	SPRI	NG	MD	ac	
31. DATE FILED (Month,		32 REGISTRAR									

FOR STATE REGISTRAR

1. DECEOENT'S NAME (First, Middle, Last)

Scott Cohen

31. DATE FILED (Month, Day, Year)
OCT 2 7 1995

D.

Jean Elizabeth McCormick

1 -

DIVISION OF VITAL RECORDS, P.O. BOX 68760

	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In)	yrs. last birthday)	MONTHS	DAYS	IF UNDER 24 HRS	10.4	OF BIRTH h, Day, Year)		8. BIRTHPLAC Country)	E (State or Foreign
Jil.	087-14-4826	1 🗆 M 2 🔀 F	72	YRS.				Jan.		1923	New Y	ork
_	Se. FACILITY NAME (If not institution, give	e street end number)			9b. CITY,	TOWN C	R LOCATION OF	DEATH		9c. COUN	TY OF DEATH	
CTOR	Suburban Hospit	al			Ве	the	sda			Mo	ntgome	ry
S I	10a. STATE 10b. COU	NTY		t0c. CIT	Y, TOWN O	R LOCAT	TION				10d.	INSIDE CITY
DIPE	Maryland Mon	ntgomery		Roc	kvil]	le						YES 2 NO
3	10e. STREET AND NUMBER					101	ZIP CODE			tog. CITIZ	EN OF WHAT	COUNTRY?
FUNERAL	1122 Parrish Dri	ve					20851				ed Sta	tes
BY	11. MARITAL STATUS 1 X Never Married 2 Merried 3 Wildowed 4 Divorced	12. WAS DECEDE FORCES? IF YES, GIVE	1 YES	2 X NO	lf.	yee, sp	ecity Cuban, Mei	cican, Puerto		es or No —	Black, Whi Specify:	mericen Indien, te, etc. White
	15. DECEDENT'S E (Specify only highest gr		1	6a. DECEDENT'S	work done d	CUPATIO	ON ast of working	161	. KIND OF B	USINESS/INDU	USTRY	
LEI I	Elementary/Secondary (0-12)	College (1-4 or 6	+)	Secret	ise retired.)			ι	J.S. G	overnn	nent	
COMP	17. FATHER'S NAME (First, Middle, Last)						16. MOTHER'S					
C	David McCormick						Vero	nica V	ricker	s		
9	19e. INFORMANT'S NAME (Type/Print)			195. MAILING	G ADDRESS	(Street e	and Number or Ru	rel Route Nun	ber, City or To	own, State, Zip	Code)	
2	Wayne Dessingue			15 Ri	ce Mt	. P	lace,	Troy,	New Y	ork 1	12182	
	20a. METHOD OF DISPOSITION 15 Burlel 2 Cremetion 3 R 4 Donation 6 Other (Specify)	emoval from State		LACE AND DATE				, 1993	20c. L	OCATION — C		
-	21, SIGNATURE OF FUNERAL SERVICE	_	_ St	. Agnes	Ceme	eter	Y ND ADDRESS OF	EACH ITY T	Co	hoes,	New Y	ork
_	23. PART I. Enter the diseases,				Hor Wis	ne/E	ethesda sin Av	a-Chevenue,	y Cha Bethe	se, Ir	nc. 75 Maryla	57 nd 208 Approximate
	shock, or heart failu	re. List only one ca	use on eac	h line.								Onset and I
	disease or condition resulting in death)	Lung	Cance	r							!	1 Year
	readiting in death)	DUE T	O (OR AS A C	ONSEQUENCE O	OF):							
z	Sequentially list conditions,	b										
Ĕ	if any, leading to immediate cause. Enter UNDERLYING	DUE T	O (OR AS A C	ONSEQUENCE (DF):							
SE	CAUSE (Disease or Injury	c	O (OR AS A C	ONSEQUENCE (OFI:						i	
ERTIFICATION	that initiated events resulting in death) LAST											
8												
N.	PART II. Other significant condi					derlyin	g cause given	in Part I.		AN AUTOPSY ORMED?	AWA	E AUTOPSY FIND LABLE PRIOR TO
	Chronic Obstruc	tive Pulm	onary	Diseas	e				t XYES	2 NO		PLETION OF CAU DEATH?
DIC				DEATH 14	- 1771 h	10 5	7				1	YES 2 NO
MEDICAL				DEATH Y	F2 XI L	40 F	UNCERT	AIN L				
AN: MEDIC	DID TOBACCO USE COI				ATM (Check	ann san						
ICIAN:	25. WAS CASE REFERRED TO MEDICA EXAMINER?	HOSPITAL:	26	S. PLACE OF OE	OTHER	t:						
SICIAN:	25. WAS CASE REFERRED TO MEDICA EXAMINER? 1 YES 2 X NO	HOSPITAL:	☐ ER/Outpet	S. PLACE OF OEA	OTHER 4 Num	t: ilng Hon	ne 6 🗆 Resider	7		V INJURY OCC	CURED	
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICA EXAMINER? 1 VES 2 X NO 27. MANNER OF DEATH t X Netural 5 Pending	HOSPITAL: X Inpetient 2 28e. DATE ((Month,	☐ ER/Outpet	DOA	OTHER 4 Num	t: ilng Hon 28c. IN.	ne 6 Resider	28d. DE		V INJURY OCC	CURED	
BY PHYSICIAN:	25. WAS CASE REFERRED TO MEDICA EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH t Netural 5 Pending Investigati	HOSPITAL: Inpetient 2 28e. DATE (Month,	ER/Outpet DE INJURY Day, Year)	DOA	OTHER 4 Num ME OF JURY	28c, IN. W	ne 6 Resider JURY AT DRK? YES 2 NO	28d. D8	SCRIBE HOV	et end Number		Number,
D BY PHYSICIAN:	25. WAS CASE REFERRED TO MEDICA EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH t Notural 5 Pending	HOSPITAL: 1% Inpetient 2 28e. DATE ((Month,) 28e. PLACE buildin	ER/Outpet DE INJURY Day, Year)	B. PLACE OF OE/	OTHER 4 Num ME OF JURY	28c, IN. W	ne 6 Resider JURY AT DRK? YES 2 NO	28d. D8	SCRIBE HOV	et end Number		Number,
D BY PHYSICIAN:	25. WAS CASE REFERRED TO MEDICA EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigati 3 Suicide 6 Could not determine.	HOSPITAL: 1% Inpetient 2 28e. DATE ((Month,) 28e. PLACE buildin	□ ER/Outpat □ ER/Outpat OF INJURY Day, Year) OF INJURY of INJURY g, atc. (Specify	S. PLACE OF OE/	OTHER 4 Num ME OF JURY M , street, factor	28c, IN. William Hon 1 Dory, office	ne 6 Resider JURY AT DRK? YES 2 NO	28d. DE	CATION (Street or Town, Ste	et end Number ite)	or Rural Route	Number,
D BY PHYSICIAN:	25. WAS CASE REFERRED TO MEDICA EXAMINER? 1 YES 2 X NO 27. MANNER OF DEATH 1 X Neturel 5 Pending Investigati 3 Suicide 6 Could not determine 29e. CERTIFIER (Check only) 1 X CERTIFYING PI	HOSPITAL: 1X Inpetient 2 28e. DATE ((Month). 28e. PLACE bellidin	ER/Outpat ER/Outpat F INJURY Day, 'fear') OF INJURY g, atc. (Specify)	s. PLACE OF OE/	OTHER 4 Num ME OF JURY M , street, factored at the ti	t: iling Hon 28c. IN. W 1 ory, office	ne 6 Resider JURY AT DRK? YES 2 NO	28d. Dt 28f. LO Ch	CATION (Street or Town, Ste	et end Number ite)	or Rural Route	
BY PHYSICIAN:	25. WAS CASE REFERRED TO MEDICA EXAMINER? 1 YES 2 X NO 27. MANNER OF DEATH 1 X Neturel 5 Pending Investigati 3 Suicide 6 Could not determine 29e. CERTIFIER (Check only) 1 X CERTIFYING PI	HOSPITAL: 15() Inpetient 2 28e. DATE ((Month,) 28e. PLACE buildin 1 (YSICIAN: To the best of	ER/Outpat ER/Outpat F INJURY Day, 'fear') OF INJURY g, atc. (Specify)	s. PLACE OF OE/	OTHER 4 Num ME OF JURY M , street, factored at the ti	t: iling Hon 28c. IN. W 1 ory, office	DERY AT ORK? YES 2 NO	28d. DE 28f. LO Ch	CATION (Street or Town, Ste	st end Number ite) nenner es state end due to th	or Rural Route	l manner es stat

Ja Dander Randel

CERTIFICATE OF DEATH

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REG. NO. 2. DATE OF DEATH MONTH 3. TIME OF DEATH October 26, 1995 3:12A 1923 New York 9c, COUNTY OF DEATH Montgomery 10d. INSIDE CITY 1X YES 2 NO 10g. CITIZEN OF WHAT COUNTRY? United States 14. RACE — American Indian, Black, White, etc. Specify: White USINESS/INDUSTRY overnment n Surneme) wn, State, Zip Code) ork 12182 OCATION — City or Town, State hoes, New York A. Pumphrey Funeral se, Inc. 7557 sda, Maryland 20814 Approximate interval Batween piratory arrest, **Onset and Death** 1 Year AN AUTOPSY ORMED? 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE 2 NO OF DEATH? 1 YES 2 NO INJURY OCCURED

OHMH-16 Rev 1/89

5454 Wisconsin Avenue, #1125, Chevy Chase, Maryland

October 26, 1995

DIVISION OF VITAL RECORDS, P.O. BOX 68760

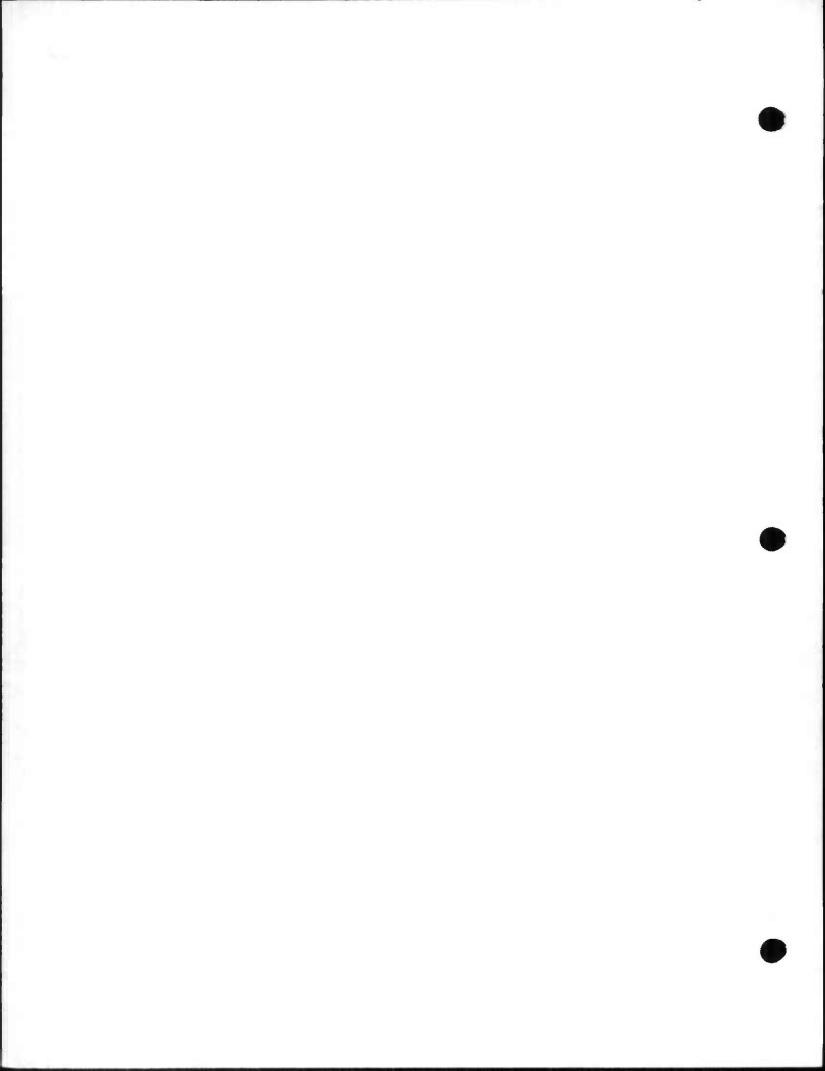
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within and hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept, of Health and Memtal Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR

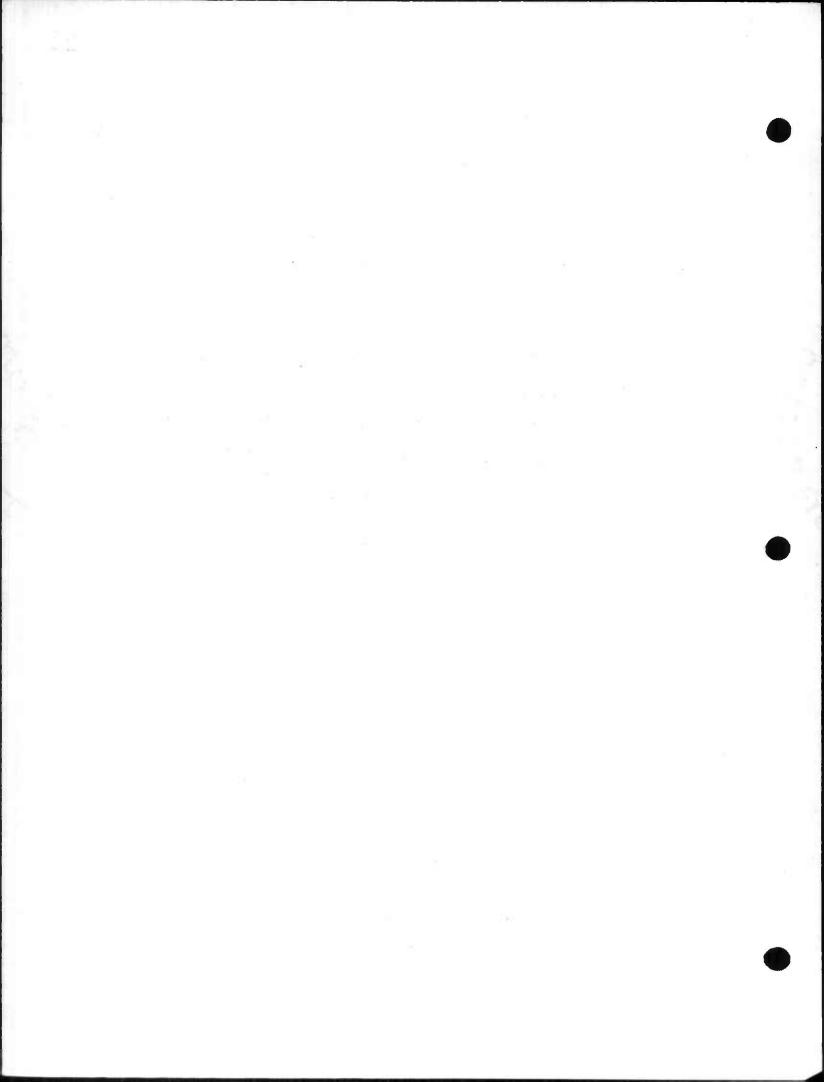
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEDENT'S NAME (First		STARBU	K	мтт	LER			-	2. DATE OF E	DA	Y 10	YEAR	3. TIME OF DEATH
	4. SOCIAL SECURITY NUME		5. SEX	6. AGE (In yrs. In			R t YEAR	# UNDER	24 HRS.	Octobe 7. DATE OF B	нтян		O. BIRTH	6:37 A M IPLACE (State or Foreign
	358–26–5016		1 🗆 M 2 💢 F	86	YRS.	MONTHS	DAYS	HOURS	MIN.	November November	r 12,	1908	IÓWA	7)
OR	98. FACILITY NAME (# not in 7825 Strat	ford R					y, town ether	OR LOCATION	ON OF D	EATH		9c. COU	tgom	EATH
DIRECTOR	10a, STATE	10b. COUNTY			10c. CIT	Y, TOWN	OR LOCA	TION				_		10d. INSIDE CITY
	MAryland	Monte	gomery		Be	thes	sda							LIMITS?
FUNERAL	7825 Strat	ford R	oad		107. ZIP CODE 20814							VHAT COUNTRY?		
B	3 X Wildowed 4 □ Divorced IF YES, GIVE WAR OR DATES 1 □ YES 2 X NO Specify:										or No-	or No- 14. RACE — American Indian, Black, White, alc. Specify: White		
	15. DEC (Specify only	EDENT'S EDUC	CATION completed)	(0	ECEOENT'S	work done	durina m	ION osl of workin	10	16b, KIN	D OF BUS	INESS/INC		
COMPLETED	(Specify only highest grade completed) College (1-4 or 5+) 12 College (1-4 or 5+) Scientist												2	
BE CO	17. FATHER'S NAME (First, M Edwin Dill	er Sta	rbuck					Anr	na I	ME (First, Middle Diller				
2	Anna Mae Hu			15	19218	ADDRES FOX	s (Street xlei	and Number ght (or Aural I	Route Number, C Hagerst	ity or Town	n, Stere, Zip MD	217	742
	20e, METHOD OF DISPOSITI 1 Burial 2 Cremation 4 Donation 5 Copher	n 3 🗆 Ramo (Specify)		20b.PLACE cametery, cri	AND DATES	OF DISPOS ther place;	SITION (N Geo dica	was 1 Cer	h.	10/17 1095	20c. LO	shino		wn, State D.C.
1	21. SIGNATURE OF EURERA	L BERVICE LIC	EMSES	. 0		22.	Colu	MD ADDRES	MOT	tuary S	Serv:	ices,	Inc	
-	23. PART I. Enter the di	en.	amplications the	holo	~	- 2 2	25 M	issou	ri A	Ave. NV	V Was	sh.,D	.C.	20011
	shock, or he IMMEDIATE CAUSE (Fin disease or condition	eert Isliure. L	list only one cau	se on each line	ð.				ng, suc	n as cardiac	ог гееріі	atory arr	est,	Approximate interval Between Onset end Death
	resulting in death)	- -	DUE TO	OR AS A CONSE	OUENCE OF	200	100	PSCH	Lon	01500	356			40003
ATION	Sequentially list conditi if any, leading to immediate. Enter UNDERLY!	liate		(OR AS A CONSE	OUENCE O	F):								
CERTIFICATION	CAUSE (Disease or Inju that initieted evente resulting in deeth) LAS		DUE TO	(OR AS A CONSE	OVENCE O	F):								
	PART II. Other significe	nt conditions	contributing to	death but not	reculting i	In the U	nderlyln	g ceuse g	lven in	Part I. 24a.	WAS AN		24b.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO
MEDICAL										10	YES 2	No		COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
ž	DID TOBACCO U		IBUTE TO CA	USE OF DEA	TH YE	s 🗆	NO E	UNC	ERTAIN	۷ 🗆				
SC	25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 NO		HOSPITAL:		E OF OEAT	OTHE	R:		,					
PHYSICIAN:	27. MANNER OF DEATH	Pending	28a. DATE OF (Month, D	INJURY	28b. TIM		28c. IN.	JURY AT ORK?		8 Other (Spi 28d. DESCRIB		JURY OCC	CURED	
ED BY	2 Accident 3 Suicide 8	nvestigation Could not be	28e. PLACE O	F INJURY — At he	eme, farm, s	street, lac		YES 2	NO	281. LOCATION City or Tox		nd Number	or Rural A	loute Number,
OMPLETED	29s. CERTIFIER (Check only	FYING PHYSIC	IAN: To the best of	my knowledge, de	eath occurre	ed at the t	time, deta	and place,	and due	to the cause(s)	and man	ner sa atate	ed.	
S S S				amination and/or	Investigatio	n, in my o	opinion, c	leath occur	ed at the	time, data and	place, and	dus to the	e cause(a)	and manner as stated.
O BE	NATURE AND TITLE	Him	ay met					29c. LICE	NSE NUN 8480	BER			SIGNEO	(Month, Dey, Year)
	30. NAME AND ACCRESS OF Gerald Snow	PERSON WHO	4900 Mas	sachuse	tts A	Print) Avenu	ue,	NW, S	Suite	e 300,	Wash	ningt	on,	DC 20016
	31. DATE FILED (Month, Day, 1 OCT 24 19!		32 REGISTRA	r's signature chardall										
	۲	-					-				-			



RECORDS, P.O. BOX 6876 BALTIMORE, MARYLAND 21215-0020	TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	c certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	be filed within 72 hours after death with the State Dept; of Health and Memtal Hygiene prior to burial, cremation, or removal.	d, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 6876	TENDING PHYSICIAN: The law requires that the death certificate be (TOR: After this certificate has been signed by the attending physician	after death with the State Dept. of Health and Mental Hygiene prior to	28 is marked, or item 23 shows any Injury, or other traun
DIA	TO THE HOSPITAL OR AT	TO THE FUNERAL DIRECTOR: After this	be filed within 72 hours a	IMPORTANT: If Item 28 is marked,

	FOR 1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPARTM			MENTAL	HYGIENI REG. NO.					
	1. DECEDENT'S NAME (First, Middle, Lest)		OEIIII IO	AIL OI	DEATH		OF OEATH		3. TIME OF DEATH			
	Roy Dennis Morn	rison, II				Octo	ber 2	2, 199	5 3:30 P	м		
	4. SOCIAL SECURITY NUMBER	IF UNDER 24 HRS.	7. DATE C	BIRTHPLACE (State or Foreign								
	555-34-9868	1 □ M 2 □ F 68	YRS.	HTHS DAYS		Dec.	Aonth, Day, Year) Country) c.30,1926 Texas					
œ	Se. FACILITY NAME (If not Institution, give at	reet end number)	ŀ		R LOCATION OF DE	EATH		9c. COUNTY				
FUNERAL DIRECTOR	2611 Evans Drive			Silver	Spring	-		Monte	omery			
RE	toe. STATE 10b. COUNTY		,	OWN OR LOCAT					10d. INSIDE CITY LIMITS?			
٥	Maryland Mont	gomery	Silve	er Spri					1 YES 2 K NO			
RA	The state of the s			101	ZIP CODE			17	OF WHAT COUNTRY?			
NE.	2611 Evans Drive	12. WAS DECEDENT EVER IN	IIIS ARMED	12 WAS DEC	20902 ENDENT OF HISPAI	NIC OBICINE	Managar Van		S.A. RACE — American Indian.			
	t Never Married 2 🙀 Married	FORCES? 1 YES	2 NO	If yea, apo	ecity Cuban, Maxica 2 X NO Specifi	in, Puerto R		or No.— 14.	Black, White, alc. Specify:			
В	3 Wildowed 4 Divorced	77 1201 0172 1011 011 01		1 123	z (A) NO Specin	у.		B	lack			
COMPLETED	ts. DECEDENT'S EDUC (Specify only highest grade		16a. DECEDENT'S USI	done during mo		16b.	KIND OF BUS	INESS/INDUST	TRY			
Ä	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT use re									
NO.	17. FATHER'S NAME (First, Middle, Last)	5+	Prof	fessor	18. MOTHER'S NA		Educat			_		
	Roy D. Morrison,	Sr			Louis			sorrianne)				
) BE	19a. INFORMANT'S NAME (Type/Print)	DI.	19b. MAILING AD	DRESS (Street a	nd Number or Rural			, State, Zip Coo	de)			
2	Margaret C. Morr	ison	2611 Eva	ans Dri	ve Sivl	ler S	pring,	Mary1	and 20902			
	20e. METHOD OF DISPOSITION t ☐ Burlel 2 ☆ Cremation 3 ☐ Remo	num! from Ctota	PLACE AND DATE OF D			DATE			or Town, Slate			
	4 Donallon 5 Other (Specify)	Me	tropolitar	n Crema	tory 10/	/23/9	Alex	andria	,Virginia			
	111	ENSEE		Franci	D ADDRESS OF FA	llins	Funer	al Hom	e, Inc.			
	Joh /	8							r.,MD 20901			
	23. PART I. Enter the diseases, or e ahock, or heart fellure. I	omplications that caused List only one cause on e		enter the mo	de of dying, auc	h as card	lac or reapli	ratory arrest	Approximata interval Batween	en		
	iMMEDIATE CAUSE (Fine)								Oneet and Das			
ļ	reaulting in death)	Chronic Lym	phcytic Le	eukemia					4 Years			
_									6 77	П		
Ö	Sequentially list conditions, if any, leading to immediate	b. Coronary Ar	CONSEQUENCE OF):	ase					6 Years			
CAT	cause. Enter UNDERLYING CAUSE (Disease or Injury	č										
E	that initieted events	DUE TO (OR AS A	CONSEQUENCE OF):									
CERTIFICATION	Todalily CAS	1			-					-		
	PART ii. Other aignificent condition	e contributing to deeth b	ut not resulting in t	the underlying	g ceuse given in	Part i.	24a. WAS AN		24b. WERE AUTOPSY FINDING AWAILABLE PRIOR TO	GS		
20	Diabetes Mell	itus				_	1 YES 2		COMPLETION OF CAUSE OF DEATH?	Ē		
ME									1 YES 2 NO			
PHYSICIAN: MEDICAL	DID TOBACCO USE CONTE				UNCERTAIL	ИП						
2	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		THER:								
HYS	1 ☐ YES 2 ☒ NO 27. MANNER OF DEATH	1 Inpatient 2 ER/Outp	28b. TIME O		6 5 X Residence			JURY OCCUR	ED.			
	t 🔯 Netural 5 🗌 Pending	(Month, Day, Year)	INJUR	Y WO	PRK?	200. DEQ	CRIBE HOW W	SONT OCCON	EU			
Э ВУ	2 Accident Investigation 3 Suicide 6 Could not be	26a. PLACE OF INJURY	- Al home, ferm, etre					nd Number or I	Rural Route Number,			
COMPLETED	4 Homicide determined	building, atc. (Spec	cny)			City o	v Town, State)					
PLE	29a. CERTIFIER 1 CERTIFYING PHYSII	CIAN: To the best of my know	ledge, death occurred a	it line time, date	and place, and due	to the cau	e(a) and man	ner as stated.				
MO	and the same of th								ruse(s) and manner as stated.			
BE C	296. SINNATURE AND TITLE OF CERTIFIES				29c. LICENSE NUI	MBER		29d. DATE SI	GNED (Month, Day, Year)			
TO B	Caml &	a year der	1)		D 23783			Octo	ber 23,1995			
	30. NAME AND ADDRESS OF PERSON WHO											
0	Daniel Esposito 31. DATE FILED (Month, Day, Year)	M.D. 5530	Wisconsin	n Avenu	e Chevy	Chas	se, Ma	ryland	20815			
	DOT 9 A 100F	Julia Davidson Ro										



IOX 68760 BALTIMORE, MARYLAND 21215-0020 te be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. sician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit.			Pages 1, 2, 3 should
SOX 68760 BALTIMORE, MARYLAND to be executed within 24 hours after death. Page 6 may be retained by the hospite sician and completely filled in by the funeral director, page 5 should be detached	21215-0020	il or attending physician.	for use as the burial-transit permit.
SOX 68760 BALTIMORE, N te be executed within 24 hours after death. Page 6 may be n esician and completely filled in by the funeral director, page 5	MARYLAND	etained by the hospita	should be detached i
SOX 68760 The be executed within 24 hours after disciplinated in by the sisting and completely filled in by the sisting and completely filled in by the sisting and completely filled in by the sisting and completely filled in by the sisting and completely filled in by the sisting and completely filled in by the sisting and completely filled in by the sisting and completely filled in by the sistence of the siste	LTIMORE, N	eath. Page 6 may be n	funeral director, page 5
SOX 68760 te be executed within sician and completel	BA	1 24 hours after de	y filled in by the f
	30X 68760	ne be executed within	ysician and completel

DIVISION OF VITAL RECORDS, P.O. E

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or	TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attention physician and completely filled in by the funeral director, page 5 should be detached for	be filed writin 72 hours after death with the base belt, or regulation hereing his provision or brown, or removal, an entired to notified at once, IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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V: The	cate	be filed writin /z hours after cean with the state belot, to health also mental hygiene prou to buna, demander, or temoral, IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical ex
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STATE OF MARYLAND / DEPARTMENT	OF HEALTH AND	MENTAL HYGIENE
CERTIFICATE	OF DEATH	REG. NO.

	FOR 1 - STATE REGISTRAR	STATE OF MA		DEPARTMEN				HYGIENE BEG. NO.					
	1. DECEDENT'S NAME (First, Middle, Last)		2. DATE OF										
	Eleanor	C.	May					BER 19	995	7:30 PH			
	4. SOCIAL SECURITY NUMBER		B. AGE (In yrs. last	birthday) IF UND	IF UNDER 24 HRS.	7. DATE OF	BIRTH	Ī	B. BIRTH	PLACE (State-or Foreign			
	220-44-4879	1 🗆 M 2 💢 F	89	YRS. MONTH		HOURS MIN.	(Month, E	8, 190	16	Countr	nsylvania		
	9e. FACILITY NAME (If not institution, give st	met end number)	03	9h Cl	TY TOWN OF	LOCATION OF O			9c. COUN				
œ							CAIT!						
DIRECTOR	Suburban Hospita	1			Bethe	saa			IAI	ontg	omery		
E	10e. STATE 10b. COUNTY			10c. CITY, TOWY	N OR LOCATE	ON					10d. INSIDE CITY LIMITS?		
10	Maryland Mon	tgomery		Poto				1 YES 2 NO					
	10e. STREET AND NUMBER	7	10f. ZIP CODE						10g. CITI	ZEN OF V	VHAT COUNTRY?		
FUNERAL	10714 Potomac Te	nnis Lane				20854 Unit					States		
5	11. MARITAL STATUS	12. WAS DECEDENT	EVER IN U.S. ARN			NOENT OF HISPA			r No-	14. RACE	E — American Indian, c, White, atc.		
	1 Never Merried 2 Merried	IF YES, GIVE WA	YES 2 NO	°		otfy Cuban, Mexico 2 X NO Specif		en, etc.)		Speci			
ВУ	3 🔀 Widowed 4 🗌 Divorced	200 000						_			White		
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade		(G/v	EDENT'S USUAL	ne during most	N t of working	16b, K	IND OF BUSIN	IESS/IND	USTRY			
Ш	Elementary/Secondary (0-12)	College (1-4 or 5+)	Ma.	Do NOT use retired									
MP		4		Homemak	er			Own I					
8	17. FATHER'S NAME (First, Middle, Last)					18. MOTHER'S NA			ımame)				
BE	Frank L. Cole					Jenni	e Smit	h					
10	19e. INFORMANT'S NAME (Type/Print)					d Number or Rural							
-	Marcia May Hummer					Bend Tra			-		0854		
	20s. METHOD OF DISPOSITION 1 Burlel 2 X Cremetton 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of commentary, cremetory or other place) OC LOBER 21, 1995 20c. LOCATION — City or Town, State												
	4 Donation 5 Other (Specify)		Montg	omery C	remate	orium,	Inc.				ryland		
	21. SIGNATURE OF FUNERAL SERVICE LIC	2 200 AA	M008	31	cobert	A. Pumj	phrey	Funera	al H	ome/	***		
	Darbara yo //	KI JULIEN	gown	ence E	Bethes Avenue	da-Chev	y Chas sda. M	se, ind	nd 2	0814	Wisconsin -3501		
	23. PART I. Enter the discesses, of c			eth. Do not ent							Approximata		
	ahock, or heert fellure. List only see ceuse on each line. IMMEDIATE CAUSE (Final Onset and Deat												
	disease or condition										hulter		
z	Sequentially list conditions, If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):												
CERTIFICATION	Sequentielly list conditions, if any, leading to immediate	DUE TO (OR AS A CONSEO	UENCE OF):									
S	cause. Enter UNDERLYING CAUSE (Disease or injury	с											
H	that initiated events	DUE TO (OR AS A CONSEC	UENCE OF):									
ER	resulting in death) LAST	d											
	PART II. Other aignificant condition	s contributing to a	death but not re	esulting in the	underlying	ceuse given in	Pert I. 2	24a, WAS AN A	UTOPSY	248	. WERE AUTOPSY FINDINGS		
CAL	GATTENTIS,	when	R 6.T	Suc	en)	~6		PERFORM	_		AVAILABLE PRIOR TO COMPLETION OF CAUSE		
ED.						e Frank		1 TYES 27	NO		OF DEATH?		
Σ	DID TOBACCO USE CONTI	DIDLITE TO CAL	ICE AE DEAT	ru vec C	I NO []	UNCERTAL					1 YES 2 NO		
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL	KIBUTE TO CAL		E OF DEATH (Che		UNCERIAL	114 121						
C	EXAMINER?	HOSPITAL:		ОТН	IER:	. 6.5							
1YS	27. MANNER OF CEATH	28e. OATE OF I	ER/Outpatient 3	26b. TIME OF	28c, INJL	5 Residence	-	(Specify)	JURY OC	CUREO			
4	1 Natural 5 Pending	(Month, De		INJURY	woi	RK?	100.0200			OONLO			
ВУ	2 Accident Investigation	28e, PLACE OF	INJURY — At ho	me. farm. street.			28f, LOCAT	FION (Street en	d Number	or Rumi	Route Number.		
ED	3 Suicide 6 Could not be 4 Homicide determined		ntc. (Specify)					Town, Stete)					
COMPLET	290. CERTIFIER	Carlo Harles Comment	on Leonar -						D SETTING				
MP	(Check only										s) end menner ee stated.		
00			amination end/or i	nvestigation, in n	ny opinion, a	ento occured at to	e time, date e	ina piece, ena	que to tr	se ceuse(s) end menner ee stated.		
BE (296. SIGNATURE AND TITLE OF CERTIFIES					29c. LICENSE NU	JMBER!		29d. DAT	E SIGNED	(Month, Day, Year)		
	/aland	111		Ulen		209	1 17		P (4	1	15) on		
9			E OF OFATH STEE	4 27) (Type Print)									
5	38. HAME AND ADDRESS OF PERSON WH												
7	Richard H. Polle	en, M.D.	10400		icut A	venue,	#606,	Kensi	ngto	n, I	4D 20895		
T		en, M.D.		Connect	icut A	venue,	#606,	Kensi	ngto	on, I	4D 20895		

TO THE HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should
be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

032-10-6212 1X M 2 F 77 VRS. MONTHS DAYS HOURS MIN. APRIL 15, 1918 Mas 9a. FACRILITY NAME (if not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF 8c. COUNTY OF 9c. COUNTY	9:40 A ATHPLACE (State or Foreign unity) SSACHUSETTS F DEATH Untgomery 10d. INSIDE CITY LIMITS?
Nicholas A. Mocca, Sr. A. SOCIAL SECURITY NUMBER S. SEX S. AGE (In yrs. last birthday) SF UNDER 1 YEAR SF UNDER 24 HRS. T. DATE OF BIRTH Month, Day, Mear) April 15,1918 Mas	9:40 A ATHPLACE (State or Foreign unity) SSACHUSETTS F DEATH Ontgomery 10d. INSIDE CITY LIMITS?
Nicholas A. Mocca, Sr. 4. SOCIAL SECURITY NUMBER 032-10-6212 1X M 2 F 77 YRS. 6. AGE (In yrs. last birthday) 1F UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) 1 MONTTHS DAYS HOURS MAN. April 15, 1918 Mass 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF Bethesda MO Maryland Montgomery 10c. CITY, TOWN OR LOCATION Bethesda 10f. ZIP CODE 10g. CITIZEN DF 10 Never Married 2 X Married 1 Never Married 2 X Married 1 Never Married 2 X Married 1 Never Married 2 X Married 1 Divorced 1 Ves 2 X No Specify: No Ctober 23,1995 8. BIRT (Montries DAYS HOURS MAN. PS. DATE OF BIRTH (Month, Day, Year) 8. BIRT (Montries DAYS HOURS MAN. PS. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF Bethesda 10g. CITIZEN DF 10g. CITIZEN DF 11 Never Married 2 X Married 11 Never Married 2 X Married 12 Yes 2 X No Specify: 11 Yes, specify Cuben, Maxican, Pusrio Ricen, etc.) 1 Yes, specify Cuben, Maxican, Pusrio Ricen, etc.) 1 Yes, Specify Cuben, Maxican, Pusrio Ricen, etc.) 1 Yes, Specify Cuben, Maxican, Pusrio Ricen, etc.) 1 Yes, Specify Cuben, Maxican, Pusrio Ricen, etc.) 1 Yes, Specify Cuben, Maxican, Pusrio Ricen, etc.) 1 Yes, Specify Cuben, Maxican, Pusrio Ricen, etc.)	9:40 A ATHPLACE (State or Foreign unity) SSACHUSETTS F DEATH Untgomery 10d. INSIDE CITY LIMITS?
032-10-6212 1X M 2 F 77 YRS. MONTHS DAYS HOURS MAY. April 15,1918 Mas 9s. FACILITY NAME (if not institution, give street and number) 9s. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF Bethesda Mo RESIDENCE OF DECEDENT 10s. STATE 10s. COUNTY 10s. STATE 10s. COUNTY 10s. CITY, TOWN OR LOCATION Bethesda 10s. STATE 10s. CITY, TOWN OR LOCATION Bethesda 10s. CITY, TOWN OR LOCATION Bethesda 10s. STREET AND NUMBER 5006 Del Ray Avenue 10s. STREET AND NUMBER 5006 Del Ray Avenue 11. MARITAL STATUS 11. MARITAL STATUS 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 A YES 2 NO Specify Cuban, Maxlean, Puario Rican, etc.) 11. YES 2 [X NO Specify: Specify Yes or No- 11. YES 2 [X NO Specify: Specify Yes or No- 11. YES 2 [X NO Specify: Specif	ssachusetts F DEATH Ontgomery 10d. Inside City Limits?
032-10-6212 1X M 2 F 77 VRS. 032-10-6212 1X M 2 F 77 VRS. 032-10-6212 1X M 2 F 77 VRS. 033-10-6212 April 15,1918 Mas 9c. COUNTY OF 5006 Del Ray Avenue Bethesda Mo Moryland Montgomery 10c. CITY, TOWN OR LOCATION Bethesda 10f. ZIP CODE 10g. CITIZEN DF 5006 Del Ray Avenue 10g. CITIZEN DF 5006 Del Ray Avenue 11. MARITAL STATUS 1 Never Married 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 1 Yes, specify Cuban, Maxlean, Puarlo Rican, etc.) 1 Yes, specify Cuban, Maxlean, Puarlo Rican, etc.) 1 Yes 2 X NO Specify: 1 Yes 2 X NO Specify:	ssachusetts peath entgomery 10d. Inside City Limits?
98. FACILITY NAME (If not institution, give street and number) 5006 Del Ray Avenue Bethesda Mo RESIDENCE OF DECEDENT 108. STATE 108. COUNTY Maryland Montgomery 109. CITY, TOWN OR LOCATION Bethesda 109. CITY, TOWN OR LOCATION Bethesda 109. CITYZEN DF 5006 Del Ray Avenue 109. CITYZEN DF 5006 Del Ray Avenue 11. MARITAL STATUS 1 Never Married 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—PORCES? 14. YES 2 NO Specify: 1 Yes, specify Cuban, Maxican, Puario Rican, etc.) 1 Yes, Specify: 1 Yes, Specify: 1 Yes, Specify: 1 Yes 2 NO Specify:	ontgomery 10d. INSIDE CITY LIMITS?
RESIDENCE OF DECEDENT 10s. STATE 10b. COUNTY Maryland Montgomery 10c. CITY, TOWN OR LOCATION Bethesda 10s. STREET AND NUMBER 10s. STREET AND N	10d. INSIDE CITY LIMITS?
10c. CITY, TOWN OR LOCATION Maryland Montgomery Bethesda 10c. CITY, TOWN OR LOCATION Bethesda 10c. CITY, TOWN OR LOCATION Bethesda 10c. CITY, TOWN OR LOCATION Bethesda 10c. CITY, TOWN OR LOCATION Bethesda 10c. CITY, TOWN OR LOCATION 10c. CITY, TOWN	LIMITS?
10e. STREET AND NUMBER 5006 Del Ray Avenue 12. WAS DECEDENT EVER IN U.S. ARMED 1 Never Married 2 X Married 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No— If yee, specify Cuban, Maxican, Puario Rican, etc.) 1 Never Married 2 X Married 15. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY	
10e. STREET AND NUMBER 5006 Del Ray Avenue 12. Was decedent ever in u.s. armed for cuben Married 2 X Married 13. Widowed 4 Divorced 14. PAR OR DATES World War II 15. Decedent's Education 16e. Decedent's usual occupation 10f. ZIP Code 20814 Unite 19. Was decending (Specify Yee or No— lif yee, specify Cuben, Maxican, Puario Rican, etc.) 1	1 YES 2 K NO
5006 Del Ray Avenue 11. MARITAL STATUS 11. MARITAL STATUS 12. Was DECEDENT EVER IN U.S. ARMED FORCES? 1 \(\tilde{\text{N}}\) YES 2 \(\text{ND}\) 15. Ness DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No— If yes, specify Cuben, Mexican, Puario Ricen, etc.) 16. DECEDENT'S EDUCATION 16. DECEDENT'S USUAL OCCUPATION 16. LECEDENT'S USUAL OCCUPATION 17. LECEDENT'S USUAL OCCUPATION 18. LECEDENT'S USUAL OCCUPATION 18. LECEDENT'S USUAL OCCUPATION 18. LECEDENT'S USUAL OCCUPATION 18. LECEDENT'S USUAL OCCUPATION 19. LECEDENT'S USUAL OCCUPATION 19. LECEDENT'S USUAL OCCUPATION 19. LECEDENT'S USUAL OCCUPATION 19. LECEDENT'S USUAL OCCUPATION 19. LECEDENT'S USUAL OCCUPATION 19. LECEDENT'S USUAL OCCUPATION 19. LECEDENT'S USUAL OCCUPATION 19. LECEDENT'S USUAL OCCUPATION 19. LECEDENT'S USUAL OCCUPATION 19. LECEDENT'S USUAL OCCUPATION 19. LECEDENT'S USUAL OCCUPATION 19. LECEDENT'S USUAL OCCUPATION 19. LECEDENT'S USUAL OCCUPATION 19. LECEDENT'S USUAL OCCUPATION 19. LECEDENT'S USUAL OCCUPATION 19. LECEDENT'S USUAL OCCUPATION 19. LECEDENT'S USUAL OCCUPATION	F WHAT COUNTRY?
11. MARITAL STATUS 1	
1 Never Married 2 X Married 1 PORCES? 1 YES 2 ND If yes, specify Cuban, Mexican, Puerio Ricen, etc.) 1 YES, GIVE WAR OR DATES World War II 15. DECEDENT'S EDUCATION 168. DECEDENT'S USUAL OCCUPATION 169. KIND OF BUSINESS/INDUSTRY	
15. DECEDENT'S EDUCATION 160. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY	ACE — American Indian, lack, White, atc. pec/ly: White
(Specify only highest grade completed) (Give kind of work done during most of working life. Do Not use relimed.)	
Elementary/Secondary (0-12) College (1-4 or 5 +)	N
- 5+ Dentist Group Health A	Association
17. FATHER'S NAME (First, Middle, Lest) 16. MOTHER'S NAME (First, Middle, Maiden Sumame)	
Louis Mocca Genevieve Cardinall	li
19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Yown, State, Zip Code)	
Anna M. Mocca 5006 Del Ray Avenue, Bethesda, Maryland	20814
208. METHOD OF DISPOSITION 200. PLACE AND DATE OF DISPOSITION (Name of 27 1 000 ATE 200. LOCATION — City of	Town, Stata
20a. METHOD OF DISPOSITION 1 X Burlel 2 Cremetion 3 Removal from State 4 Donation 6 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of came terry) 20c. LOCATION — City or Cher place) OCTOBER 27, 1995 Sate of Heaven Cemetery Silver Spri	ing, Marylan
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY ROBERT A. Pump	
Home/Bethesda-Chevy Chase, Inc. Wisconsin Ave., Bethesda, MD 20	7557 814-3501
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest,	Approximate
shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final	Onset and Dag
disease or condition	
resulting in death) a. End Stage Alzheimer's Disease Due to (or as a consequence or):	
The state of the s	
Sequentially list conditions, Due to (DR AS A CONSEQUENCE OF):	
If any, leading to immediate couse. Enter UNDERLYING	İ
CAUSE (Disease or Injury	
that initiated events resulting in death) LAST	
d.	
	24b. WERE AUTOPSY FINDING
Parkinson's Disease	AVAILABLE PRIOR TO COMPLETION OF CAUSE
1 □ YES 2 X ND	DF DEATH?
	1 TYES 2 X NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO M UNCERTAIN	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL:	
EXAMINER? 1 X YES 2 NO 1 Inpetient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify)	
27. MANNER OF DEATH 280. DATE DF INJURY 26b. TIME OF 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED)
Notural 5 Pending (Month, Day, Year) INJURY WORK? 1 YES 2 NO	
28s. PLACE OF INJURY — At home farm, street, factory office. 28s. PLACE OF INJURY — At home farm, street, factory office.	ral Route Number,
3 Suicide 6 Could not be 4 Homicide determined City or Town, State)	
29a. CERTIFIER (Check only 1 XCERTIFYINO PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.	
one) 2 MEDICAL EXAMINER: Dn the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause	se(s) and manner as stated.
SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGN	NED (Month, Day, Year)
D20367 Octo	ober 24,1995

October 24,1995 020367 ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) D., 6111 Executive Blvd., Rockville, Maryland
32. MEDISTRAN'S SIGNATURED

July & West Son Mardell Joel P. M.D., Kalman, 20852 31. DATE FILED (Month: Ton 265 1995

9c. COUNTY OF DEATN

Montgomery

10g. CITIZEN OF WHAT COUNTRY?

USA

14. RACE — American Indian, Black, White, etc.

3. TIME OF DEATH

Washington, DC

10d. INSIDE CITY

1 K YES 2 NO

White

20895

Interval Between Onset and Death

24b. WERE AUTOPSY FINDINGS

AMILABLE PRIOR TO

1 YES 2 NO

or Burel Route Number

aug

COMPLETION OF CAUSE

De.

20c. LOCATION - City or Town, State

PERFORMED?

Strath

WISCOUSIN

Merca

29d. DATE SIGNED (Month, Day, Year)

BC+ 25

8. BIRTHPLACE (State or Foreign

9:55 A M

REG. NO

2. DATE OF DEATN

October 21,

FOR STATE REGISTRAR

Agnes

1. DECEDENT'S NAME (First, Middle, Last)

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4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH
(Month, Day, Year)
Sept.17,1916 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 24 HRS. 79 215-54-6699 1 M 2 X F Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR Carriage Hill - Bethesda Bethesda RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10b. COUNTY Maryland Montgomery Kensington permit. FUNERAL 10e. STREET AND NUMBER 10f ZIP CODE 4920 Strathmore Avenue 20895 use as the burial-transit 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO with. 24 hours after death. Page 6 may be retained by the hospital or attending physician. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-FORCES? 1 YES 2 If yes, specify Cuben, Mexicen, Puerto Rican, etc.)

1 ☐ YES 2 🔀 NO Specify: 1 Never Married 2 Merried BY 3 Widowed 4 Divorced ETED 15. DECEDENT'S EDUCATION 18e. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high (Give kind of work done life. Do NOT use retired.) page 5 should be detached for Elementary/Secondary (0-12) College (1-4 or 5+) 5+ COMPL Teacher Education 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Meiden Sumeme) John McCarthy Bridget Reed 76 notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sister Maureen Patrice, C.S.C. 4920 Strathmore Avenue, Kensington, MD 90 20e. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of must 1 💢 Buriel 2 🗆 Cremetion 3 🗆 Re funeral director, Gate of Heaven Cemetery 10/24/95 Silver Spring, MD 4 Donation 5 Other (Specify) examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSER 22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd.W. Sil.Spr.MD 20901 filled in by the ion or removal. the medicai 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final the cremation. Cerebro vescular acciden T disease or condition completely resulting in death) other traumatic event, DUE TO (OR AS A CONSEQUENCE OF): executed burial. Sub Hematoma Devo CERTIFICATION and Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF). signed by the attending physician a Health and Mental Hygiene prior to If sny, leading to immediate cause. Enter UNDERLYING 3 certificate CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated eventa resulting in death) LAST 6 death injury, PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY MEDICAL the that shows any 1 YES 2 NO requires this certificate has been a with the State Dept. of F DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: AND N 23 28. PLACE OF DEATN (Check only one, 25. WAS CASE REFERRED TO MEDICAL Item EXAMINER? HOSPITAL QTHER:
4 Nursing Name 5 - Residence ☐ Inpetient 2 ☐ ER/Outpetient 3 ☐ DOA OR ATTENDING PHYSICIAN: 10 27. MANNER OF DEATN 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE NOW INJURY OCCURED marked, 1 Natural 5 Pending PM 1 YES 95 DIRECTOR: After the hours after death v BY 2 Accident Investigation 3 Suicide 28e. PLACE OF INJURY - At home, ferm, street, fectory, office 281. LOCATION (Street City or Town, Stete 28 is i 8 Could not be determined COMPLETED 4 Homicide CONvent 4920 J THE HOSPING.
TO THE FUNERAL DIRECTOR MICHORAL DIRECTOR MICHIGAN MICHIAN MICHIGAN M Hem 29e. CERTIFIER 1/Check only 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(e) and menner as stated. 2 MEDICAL EXAMINER: On the beele of exemination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) end manner es stated. 29b. SIGNATURE AND TITLE OF CER 29c. LICENSE NUMBER BE D082 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

bor

32. REGISTRAR'S SENATURE

8218

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26 1995

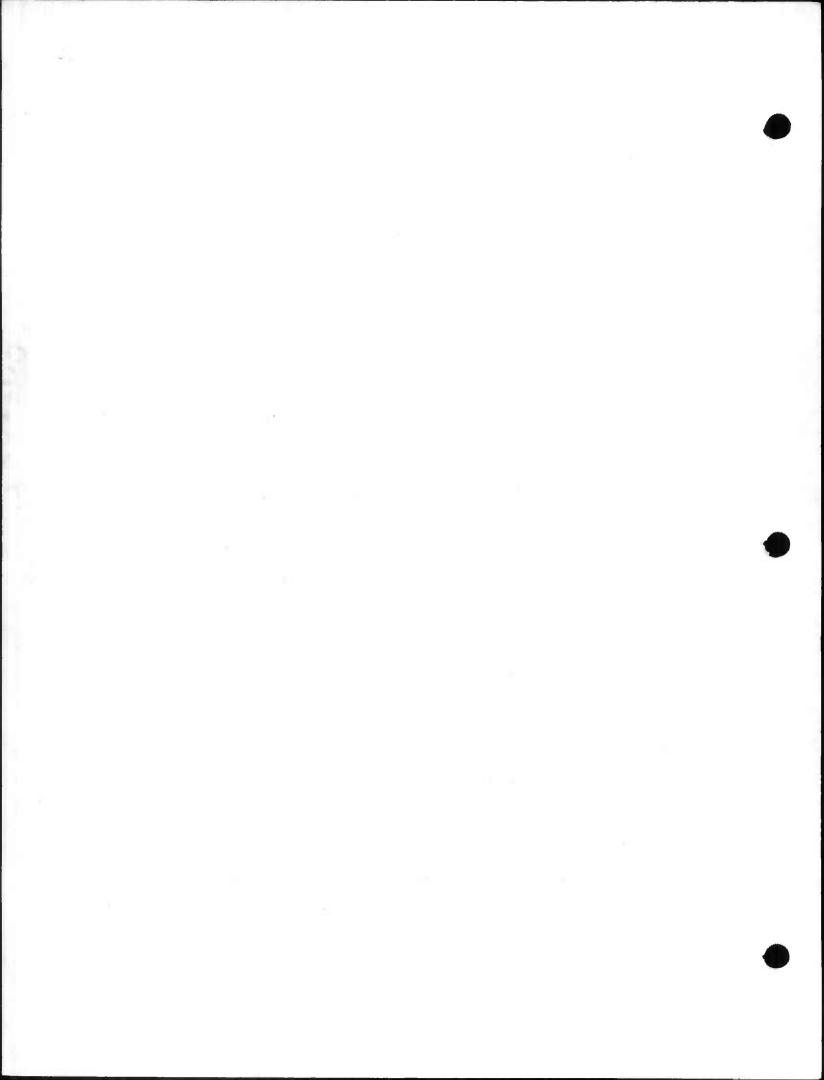
31. DATE FILED (Month, Day, Year)

McCarthy

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	FOR 1 - STATE REGISTRAR	STATE OF) / DEPAI					MENT	AL HYGIEN			
-	1. DECEDENT'S NAME (First, Middle, Lest) Raymond Everett Nicholas 2. Date of Death Cooper 23, 1995 YEAR 4:00 P												
	4. SOCIAL SECURITY NUMBER 220-28-4713	5. SEX 1 🖔 M 2 🗌 F	6. AGE (In yrs. 76	last birthday) YRS.	IF UNDER	1 YEAR DAYS	IF UNDER	24 HRS.	7. DAT	e of sinth	1919	8. BIRTI Count	PLACE (State or Foreign Pennsylvania
TOR	98. FACILITY NAME (If not institution, give street and number) 4823 Vienna Rhodesdale Road 96. CTY, TOWN OR LOCATION OF DEATH Vienna POSC COUNTY OF DEATH Dorchester								EATH				
DIRECTOR	10a, STATE 10b, COUNTY	rchester			v, rown d Vienr		TION		-				10d, INSIDE CITY LIMITS?
FUNERAL	100. STREET AND NUMBER 4823 Vienna Rhodesdale Road 101. ZIP CODE US US												
B	A TANK MALINE TALL MALINE TO THE PARTY OF TH								E — American Indian, k, Whije, etc. My: White				
COMPLETED	15. DECEDENT'S EDU- (Specify only highest grade Elementary/Secondary (0-12)			Give kind of the Do NOT u	work done			פי	16	Agric			
E COMF	17. FATHER'S NAME (First, Middle, Lest) Raymond Nichol			rarin	CI			HER'S NA		Middle, Maider		re	
TO BE	19a. INFORMANT'S NAME (Type/Print) Louise K. Nichola	as_							Route Nur	mber, City or Tox			yland 21869
	20a. METHOD OF DISPOSITION 1 \(\Omega\) Buriel 2 \(\omega\) Cremation 3 \(\omega\) Rem 4 \(\omega\) Donation 5 \(\omega\) Other (Specify)		20b. PLAC cometery, Arli	crematory or o	Nati	ona	1 Cer	nete	ry 1	0/26 A	rling	chy or To	wm, state , Virginia
	An J Lorra	·			7	homa 200 1	Locus	iner st S	al H	ome, F ambrid	lge, l	Mary.	land 21613
	23. PART I. Enter the diseases, or o shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. Rusi	it caused the use on each I	death. Do	not anier	the mo	de of dy	ng, suc	h as ca	rdiac or resp	olratory ar	reat,	Approximate Interval Between Onset and Death
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. CAMA DUE TO	(OR AS A CONS			Cin	desp	May		julali	m		MTHS
MEDICAL	PART II. Other significant condition	s contributing to	death but no	ot resulting	in the un	deriying	j cause (given in	Part I.	24s. WAS AN PERFO 1 YES	RMED?	246	WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			OTHER		ACE OF D	EATH (Ch	eck only o	one)			
HYS	1 ☐ YES 2 ⋈ NO 27. MANNER OF DEATH	1 Inpatient 2 I		3 DOA 28b. TIM	4 🗆 Nun			sidence		er (Specify)	IN HIRW OC	CHRED	
BY PI	1 Netural 5 Pending	(Month, D	lay, Year)	IN.	JURY		RK?	NO	200. UE	SCHIBE HOW	INJURY OC	COMED	
	2 Accident investigation						Boute Number,						
COMPLETED	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSIC DESCRIPTION 1 MEDICAL EXAMINE												s) and manner as stated.
TO BE C	29b. SIGNATURE AND TITLE OF CERTIFIER	1 Como					29c. LICI	NSE NUI			29d. DAT		(Month, Day, Year) 24-50
-	30. NAME AND ADDRESS OF PERSON WHI	W600	MD	630 (y St	reet	Sal	isb	ury, M	aryla	ınd	21801
	31. DATE FILED (Month, Day, Year) 1995	Jalia a	S SIGNATURE	Rardall									

9c. COUNTY OF DEATN

Montgomery

10g. CITIZEN OF WHAT COUNTRY?

USA

3. TIME OF DEATN

8. BIRTHPLACE (State or Foreign

10d. INSIDE CITY LIMITS?

14. RACE — American Indian, Black, White, etc.

Chinese

1 YES 2 NO

China

8:40 P

DIRECTOR

FUNERAL

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29e. CERTIFIER

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DIRECTOR: 28

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DIVISION OF VITAL RECORDS, P.O. BOX 68760	të.	B	ĕ
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	THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hour	THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in	filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or
	王	E	file

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF CEATH Julia Ng October 20 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year June 7, 6. AGE (In yrs. last birthday)
70 5. SEX IF UNDER 1 YEAR IF UNDER 24 HRS. HOURS 071-36-9565 1 M 2 X F YRS. 1925 9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH Montgomery General Hospital 01ney RESIDENCE OF DECEDENT 10e. STATE 10c. CITY, TOWN OR LOCATION Maryland Montgomery Silver Spring 10e. STREET AND NUMBER 10f. ZIP CODE 15210 Elkridge Way, #2C 20906 12. WAS OECEOENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-1 Never Married 2 1 Married FORCES? 1 YES 2 If yes, specify Cuban, Mexican, Puerto Rican, 1 TES 2 NO Specify 3 Widowed 4 Divorced 15. DECEOENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INQUSTRY (Specify only high Elementary/Secondary (0-12) 12 Hairdresser Beauty 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Pak-Ping Wong Unobtainable 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 15210 Elkridge Way, 2C, Silver Spring, Maryland Christopher Ng 20e. METNOD OF DISPOSITION 1 ☐ Burlal 2 ☐ Cremation 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State on 3 🗆 Re Fort Lincoln Cemetery 4 Donation 5- Other (Specify) 10/23 Brentwood, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue Kenu Silver Spring, Maryland 23. PART I. Enter the disesses, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory strest, shock, or heart failure. List only one ceuse on each line. **IMMEDIATE CAUSE (Finel** disease or condition resulting in death) MANITION AS A CONSEQUENCE OF): KUMONIA Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING ROPTBOSIS CAUSE (Disease or injury that initiated events resulting in deeth) LAST PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.

RENA	L TAILU	Re	
MY6 CA	EDIAL INF	ARCT	
DID TOBACCO USE CONTR	RIBUTE TO CAUSE OF DEATH	YES NO	UNCERTAIN [
25. WAS CASE REFERRED TO MEDICAL	26. PLACE DF	DEATN (Check only one)	

24s. WAS AN AUTOPSY 1 TYES 2

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?

Approximate

interval Between

Onset and Death

W K

1 YES 2 NO

1 YES 2 7 ND	HOSPITAL: 15 Inpatient 2 - ER/Outpatient 3	DOA 4 Nu	R:	6 ☐ Other (Specify)		
MANNER OF DEATH Netural 5 Pending Accident Investigation	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 YES 2 NO	28d. DESCRIBE NOW INJURY OCCURED		

3 Suicide 4 Homicide	6 Could not be determined	28e. PLACE OF INJURY — At home, lerm, street, factory, office building, etc. (Specify)	281. LOCATION (Street and Number or Rural Route Number, City or Town, State)
. CERTIFIER	CERTIEVING BUVOICIA		

	ERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(e) and manner ee stated.
R	MEDICAL EXAMINET: On the beele of examination end/or investigation, in my opinion, death occured at the time, date and place, end due to the same of manner as a

B. SURNATURE AND TYLES PRINTED MAN PAR	29c. LICENSE NUMBER D 8 6 406	29d. DATE	21	19
NAME AND ADDRESS OF PERSON WIND COMPLETED CAUSE OF GEATH (ITEM 27) (Type, Print)				

L NAME AN					COMPLETED	CAUSE	OF C	EATN	(ITEM	27) (Туре,	Print
	\mathcal{L}	OA	IDE	7	2		K	W	115		17	1
	-		and - 1			-	. 65		-	,		1

OLNEY	HO	20	18

25 1995

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3. REGISTRAR'S SIGNATURE Talia Davidson Rardall

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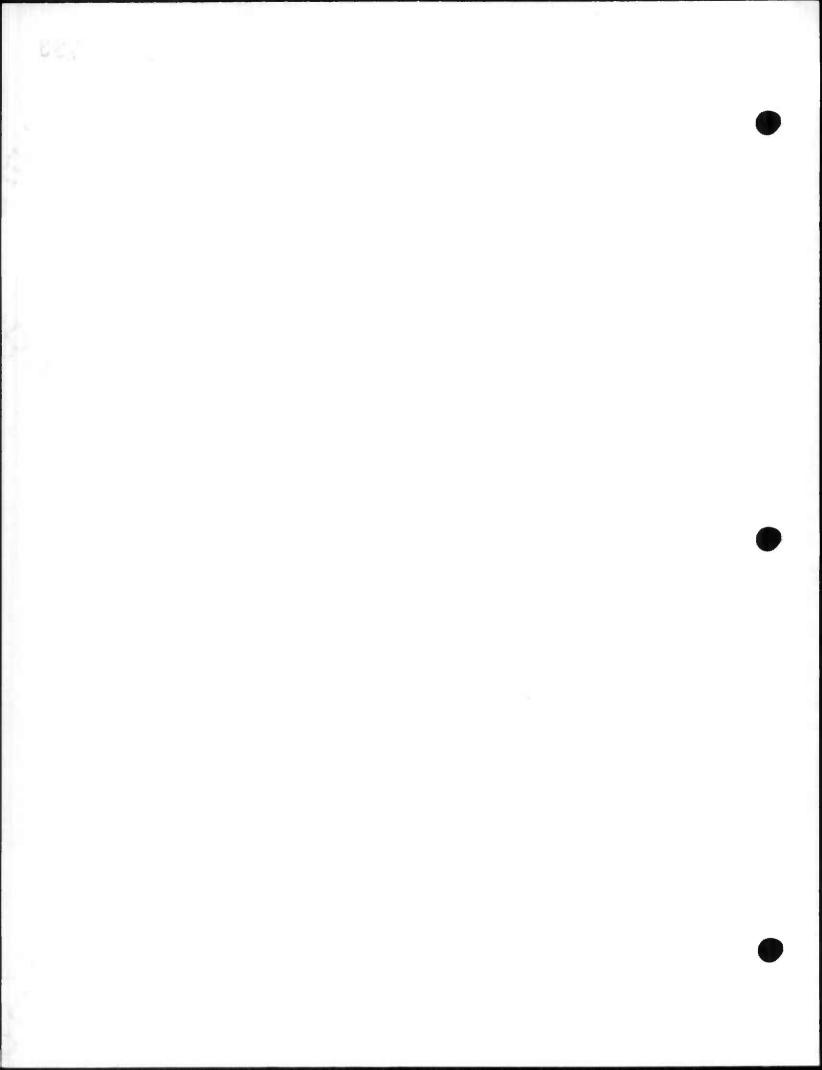
	1 • FOR STATE REGISTRAR	STATE OF MARY		RTMENT OF I		MENTAL	HYGIEN REG. NO.	E		
	. DECEDENT'S NAME (First, Middle, Last) Joyce Nanayakkara					2. DATE OF OEATH DAY YEAR 3. TIME OF DEATH MONTH 25 8:30 A				
TED BY FUNERAL DIPECTOR	4. SOCIAL SECURITY NUMBER 579-58-3808		(In yrs. lest birthday) 75 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	(Month	OF BIRTH , Day. Year) 29,19		Country	LACE (State or Foreign Lanka
	9e. FACILITY NAME (If not institution, give street and number) Bedford Court				n on Location of GEATH er Spring			Montgomery		
	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY Manual and Montgomory			10c. CITY, TOWN OR LOCATION Silver Spring			LIMITS?			10d. INSIDE CITY LIMITS?
	Maryland Montgomery 10e. STREET AND NUMBER			10f. ZIP COOE			10g. CITIZEN OF			
	3700 International 11. MARITAL STATUS 1	IN U.S. ARMED 2 ANO DATES	XNO If yes, specify Cuban, Mexican, Puerto Rican, etc.)							
	3 Widowed 4 ADivorced 15. OECEOENT'S EDU (Specify only highest grade	B USUAL OCCUPATI	rk done during most of working			White White				
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+) 4	Homes	maker	Owr			n Home		
Ö	17. FATHER'S NAME (First, Middle, Last) 18.				18. MOTHER'S NA	1a. MOTHER'S NAME (First, Middle, Melden Surname)				
BE	John Perera				Daisy	Iren	ne Men	dis		
PHYSICIAN: MEDICAL CERTIFICATION TO BI						and Number or Rural Route Number, City or Town, State, Zip Code) Terrace, Bethesda, Maryland 20817				
	20e. METHOD OF DISPOSITION 1 Burlel 2X Cremetton 3 Removal from State 4 Donetton 5 Other (Specify) 20b. PLACE ANODATE OF DISPOSITION (Name of Commence									
	23. PART I. Enter the disease, or ahock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS		ritis P:	ode of dying, suc				et,	Approximate Interval Between Onset and Deeth
	PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause grant to the supplier of the contribution of the underlying cause grant to the under					_	PERFORMEO? 1 YES 2 NO COMPLETION OF CEATIN? 1 YES 2 NO VESTION OF CEATIN?		WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DF CAUSE OF OEATH? 1 YES 2 NO	
	25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)									
SIC	1 VES 2 NO	HOSPITAL: 1 inpetient 2 ER/Ou	tpetient 3 DOA	4 Nursing Ho	me 5 🗆 Residence	6 🗆 Othe	r (Specify)			
ВУ	27, MANNER OF DEATH 1 Natural 5 Pending	28e. OATE OF INJURY 28b. TIME OF INJURY WOR!			URY AT 26d. DESCRIBE HOW INJURY OCCUREO					
	2 Accident Investigation 3 Suicide 6 Could not be determined 28e. PLACE OF INJURY — At home, term, st building, atc. (Specify)				ce	261. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
COMPLETED	29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the best of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(e) and manner as stated.									
TO BE CO	MANUFACTURE AND TITLE OF CERTIFIE	4. Song	stace	Luci	29c. LICENSE NU		2/			(Month, Day, Year)
_	George F. Sengstack, M.D., 3929 Ferrara Dr., Wheaton, Maryland 20906									
	31. DATE FILEO (MORITO, Day, Your) 32. REQUISTRAR'S SIGNATURE OCT 2.4. 1995 Six Los Structure Randall									

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10 THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL ORECTOR, After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1. 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: It Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	FOR STATE REGISTRAR	STATE OF MARY	AND / DEPART	MENT OF I	IEALTH AND I	MENTAL HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH DO OCTOBER 2	3 TIME OF DEATH		
Œ					IF UNDER 24 HRS.	7. DATE OF BIRTH	BIRTHPLACE (State or Foreign		
	180-20-4326 1 9e. FACILITY NAME (If not institution, give stree	□ M 2 💢 F	93 YRS.	ONTHS DAYS	HOURS MIN.	March 2, 1	New York		
	The second secon	1	9b. CITY, TOWN OR LOCATION OF DEATH			9c. COUNTY OF DEATH			
5	Holy Cross Hospita		Silver	Spring	Mont	Montgomery			
DIRECTOR	10a. STATE 10b. COUNTY	10c, CITY,	10c, CITY, TOWN OR LOCATION			10d. INSIDE CITY			
0	Maryland Montgomery			er Spr	ing		1 TES 2 NO		
RAI	10e. STREET AND NUMBER			. ZIP CODE			OF WHAT COUNTRY?		
BY FUNERAL	1316 Fenwick Lane 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARM			20910			United States		
	1 Never Merried 2 Merried 3 Widowed 4 Divorced 1. West Develor Even in U.S. ARK FORCES? 1 YES 2 XNI IF YES, GIVE WAR OR DATES			IED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify of the specify Cuben, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☐ NO Specify:			fee or No— 14. RACE — American Indian, Slack, White, etc. Specify: White		
9	15. DECEDENT'S EDUCAT (Specify only highest grade col	16e. DECEDENT'S US	CEDENT'S USUAL OCCUPATION Ive kind of work done during most of working				BUSINESS/INDUSTRY		
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5 +)	ille. Do NOT use	retired.)	SI OF WORKING				
MP	12 17. FATHER'S NAME (First, Middle, Last)	4 Pilot Consulting							
8	Frederick Wilcox					ME (First, Middle, Maiden	Surneme)	1 1 20	
BE	19a. INFORMANT'S NAME (Type/Print)		19b MAILING A	DDBESS /Street /	Elizabe	eth Lewis Route Number, City or Tow	- State 7's G		
2	H. Christopher Nol	.de				nington, D			
	20e. METHOD OF DISPOSITION 1 □ Burlel 2 🗘 □ Cremation 3 □ Remove	20	D. PLACE AND DATE OF	DISPOSITION (No				or Town, State	
	4 Donation 5 Other (Specify) Chesapeake Crematory 10-22 Beltsville, Marylan							e, Maryland	
	21. SIGNATURE OF FUNERAL SERVICE LICEN	SEE		Rapp	D ADDRESS OF FA	Services, I			
	Cler To	Cap	\sim	933 G:	ist Avenu	Je. Silver	Spring	, MD 20910	
NO	23. PART i. Enter the diseases, or con ahock, or heert failure. List iMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions,	DUE TO (DR AS	each line.				ratory arrest	, Approximate interval Between Onset and Death	
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST c. Hyper Heys 10 Yr Dise to (OR AS A CONSEQUENCE OF): d								
AL	PART II. Other significent conditions of	contributing to deeth i	out not resulting in	the underlyin	cause given in	Pert i. 24s. WAS AN PERFOR		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO	
ă	EMPHYSELVIA						COMPLETION OF CAUSE OF DEATH?		
M	Cerebiovascular Disease							1 TES AT NO	
AN	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)								
SIC	EXAMINER? 1 VES 2 NO	OSPITAL:	10	THER:	S C Beeldoon	e 🗆 on m			
Y PHYSICIAN: MEDIC	27. MANNER OF DEATH 1 Netural 5 Pending	OF DEATH 280. DATE OF INJURY (Month, Day, Year) 26b. TIME OF INJURY AT WORK? WORK? M 1 VFS 2 NO							
TED BY	2 Accident Investigation 3 Suicide 8 Could not be determined	— At home, ferm, stre	et, fectory, office 281. LOCATION (Street end Number or Rural Route Number, City or Town, State)						
COMPLETED	29e. CERTIFIER (Check only one) 1 CERTIFVINO PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) and manner as stated. 2 MEDICAL EXAMINER: On the bests of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(e) and manner as stated.								
TO BE C	296. SIGNATURE AND TITLE OF CERTIFIER	4D.	D 46101				TATE SLENED (Mogith, Day, Yagir)		
	GAIL J. POVAR M.D., 8700 Georgia Avenue, Silver Spring, MD 20910								
	OCT 23 1995	32. HEGISTRAR'S SIGN	x-Rardally				0		



Pages 1, 2, 3 should

permit.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the		IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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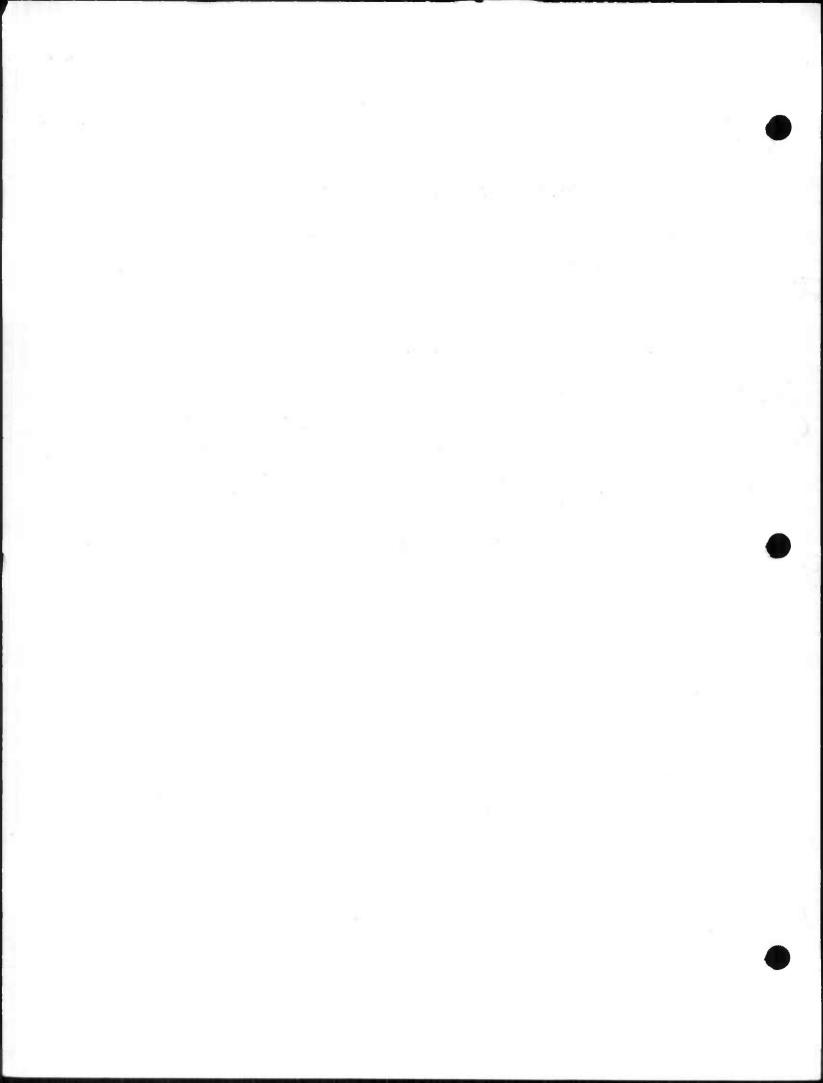
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31. DATE FILEO (Month, Day, Year)

OCT 23 1995

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 1995 Mabe Nielsen October 0600 AM 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH JUNE 1,1907 8. BIRTHPLACE (State or Foreign HOURS NEW YORK DAYS 052-10-4901 1 🗆 M 2 💢 F 88 YRS 9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF GEATH DIRECTOR SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE MONTGOMERY RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY TOWN OR LOCATION 10d. INSIDE CITY MARYLAND MONTGOMERY GAITHERSBURG 1 YES 2 NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 301 RUSSELL AVENUE #419 20877 UNITED STATES 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 TYES 2 NO IF YES, GIVE WAR OR DATES 13. WAS OECENDENT OF HISPANIC ORIGIN? (Specify Yee or No—If yes, specify Guben, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Merried 3 Widowed 4 Divorced BY WHITE COMPLETED 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15 DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY College (1-4 or 5+) Elementary/Secondery (0-12) ACCOUNTANT **AEROSPACE** 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Meiden Surname) ERWIN LEITNER **EMMA** RICHTER BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING AOORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code, 2 ARTHUR E. LEITNER 6 HOLLY LANE JERICHO, NEW YORK 11753 20e. METHOD OF DISPOSITION
1 Burlel 2 Cremetion 3 Re 20b. PLACE AND OATE OF DISPOSITION (Name of OATE 20c. LOCATION — City or Town, State METROPOLITAN CREMATORY 10/20/95 ALEXANDRIA, VIRGINIA 4 Donetion 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE MURIEL H. BARBER FUNERAL HOME · murie LAYTONSVILLE, MARYLAND BOX 5038 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Batween **Onset and Death** IMMEDIATE CAUSE (Final disease or condition OVARIAN CANCER 2 years resulting in death) DUE TO (OR AS A CONSEQUENCE OF): BREAST CIAN CETZ Years CERTIFICATION Sequentially liet conditiona, DUE TO (OR AS A CONSEQUENCE OF If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in deeth) LAST PART II. Other aignificent conditions contributing to death but not reculting in the underlying ceuse given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATN? PERFORMED? DIABETES MELLITUS 1 TES 2 NO HYPERTENSION 1 TES THO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO WIT UNCERTAIN I 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF OEATN (Check only on HOSPITAL: OTHER:
4 | Nursing Name 5 | Residence 6 | Other (Specify) 1 YES 2 NO Inpetient 2 ER/Outpetlent 3 DOA 27. MANNER OF DEATN 28s. OATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE NOW INJURY OCCURED 5 Pending Investigation 1 Natural 1 YES 2 NO ВУ 2 Accident 26e. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide ETED 8 Could not be 4 Nomicide 29e. CERTIFIER (Check only (Ch COMPL 2 MEDICAL EXAMINER: On the basic of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(e) and manner se stated. 29b. SIGNATURE AND TITLE OF CERTIFIE 29d. DATE SIGNED (Month, Day, Year) 29c. LICENSE NUMBER Luhot D31720 ma- , cu R 9



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	1. DECEDENT'S NAME (Fin	Moi	' I	W15	No	irth				_ MON	TE OF DEATH DA		OG5	3. TIME OF DEATH
	4. SOCIAL SECURITY NUM 577-86-1010		5. SEX 1 ☐ M 2 🎇 F	6. AGE (In yn	s. last birthday) YRS.	IF UNDER 1 Y	EAR	IF UNDER	MIN	7. DATE (Mor	TE OF BIRTH		Count	NPLACE (State or Foreigny) XAS
	9e. FACILITY NAME (If not					9b. CITY, TOWN OR LOCATION OF DEATN								
O.	Shady Grove		ntist Hos	pital		Rockville						Mon	tgom	ery
DIRECTOR	RESIDENCE OF DE	10b. COUN	TY		10c, CIT	10c. CITY, TOWN OR LOCATION								10d. INSIDE CITY
DIR	MD	Mon	ntgomery			Rockville								LIMITS?
AP.	10e. STREET AND NUMBER							ZIP CODI	E			10g. CIT	IZEN OF	WHAT COUNTRY?
PLETED BY FUNERAL	303 Adc1a								2	0850	0	US.	A	
	11. MARITAL STATUS 1 Never Merried 2 C 3 Widowed 4 Dh	_	12. WAS DECEDEN FORCES? 1 IF YES, GIVE V	YES 2	K NO	13. WAS DECENDENT OF NISPANIC If yes, specify Cuban, Mexican, I 1 YES 2 NO Specify:				n, Puerto	C ORIGIN? (Specify Yes or No— 14. RAI b, Puerto Rican, atc.)			E — American Indian, k, White, atc. My: White
	15. DE (Specify or	pecify only highest grade completed) (Gi				USUAL OCCL			10	18	Bb. KIND OF BUS	SINESS/INI	DUSTRY	
	Elementary/Secondary	(0-12)	College (1-4 or 5	-)		nemaker					0	**		
COMPL	17. FATHER'S NAME (First,	Micidia Last)			пошет	naker	Т	40 14071	HERIO MAI	100		vn Ho	ome	
ы С	Joseph Edgar Lewis, Sr.										, Middle, Melden Snong	oumame)		
0 86	190. INFORMANT'S NAME				19b. MAILING	ADDRESS (S	treet en				mber, City or Town	n, Stata, Zi	Code)	
۲	Janis Nort	h Cook									esda, N		208	316
	11 Burlel 2 Cremat	20a. METHOD OF DISPOSITION 1XI Burlel 2 Cremation 3 X Removal from State 4 Donation 5 Other (Specify)												
	21. SIGNATURE OF FUNER		ICENSEE)	Lve	rgreen				95 OF FAC	T U	Joseph	Soni	a, .	Arkansas
	· Kan	544	Leten			5130) W	I Av	e. N	W C	Joseph Washing	ton	er's	. 20016
	23. PART I. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdisc or respiratory arrest, ehock, or heart failure. List only one ceuse on sech line. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Presson P													. 20010
	IMMEDIATE CAUSE (Fi	neart fallure	a. PC	newn	onia	not enter the								Approximate Interval Betwo
CATION	IMMEDIATE CAUSE (F disease or condition resulting in death) Sequentially list cond if any, leading to imm cause. Enter UNDERLY	itions, ediete	a. Pour TO	Se on sech	line.	not enter the								Approximate Interval Betwo
ERTIFICATION	IMMEDIATE CAUSE (F disease or condition resulting in death) Sequentially list condi if any, leading to imm	itions, ediete ring	a. PC DUE TO DUE TO	(OR AS A COM	ONIA	not enter the								Approximate Interval Betwo
MEDICAL CE	IMMEDIATE CAUSE (FI disease or condition resulting in death) Sequentially list condi if any, leading to immoduse. Enter UNDERLY CAUSE (Disease or Inj that initiated events resulting in death) LA:	Itlons, ediete ving ury st	a. PC DUE TO C. OUE TO d. Ona contributing to	(OR AS A COM	Ine. ONIA INSEQUENCE OF INSEQUENCE OF INSEQUENCE OF INSEQUENCE OF INSEQUENCE OF INSEQUENCE OF INSEQUENCE OF INSEQUENCE OF INSEQUENCE OF INSEQUENCE OF INSEQUENCE OF INSEQUENCE OF INSEQUENCE OF INSEQUENCE OF	F): F): In the under	e mod	cause ç	ing, auci	Part I.	rdiac or reapl	AUTOPSY MED?	rest,	Approximate Interval Betw Onset and D. 3H Low
MEDICAL CE	IMMEDIATE CAUSE (Fidisease or condition resulting in death) Sequentially list condition may be seen as a condition resulting in death) Sequentially list condition may be seen as a condition of the sequential may be seen as a condition of the sequential may be seen as a condition of the sequential may be seen as a condition of the sequential may be seen as a condition of the sequential may be seen as a condition of the sequential may be seen as a condition of the sequential may be seen as a condition of the sequential may be seen as a condition of the sequential may be seen as a condition of the sequential may be seen as a condition of the sequential may be seen as a condition of the sequential may be seen as a condition of the sequential may be sequentially sequential may be sequentially sequential may be sequentially sequential may be sequentially sequential may be sequentially sequential may be sequentially sequential may be sequentially sequentially sequential may be sequentially sequentially sequentially sequentially sequentially sequential may be sequentially s	Itlons, ediete ring structure struct	a. PC DUE TO b. DUE TO c. OUE TO d. TRIBUTE TO CA	(OR AS A COM	Ine. ONIA INSEQUENCE OF INSEQUENCE OF INSEQUENCE OF INSEQUENCE OF INSEQUENCE OF INSEQUENCE OF INSEQUENCE OF INSEQUENCE OF INSEQUENCE OF INSEQUENCE OF INSEQUENCE OF INSEQUENCE OF INSEQUENCE OF INSEQUENCE OF	F): F): In the under	e mod	cause ç	ing, auci	Part I.	24e. WAS AN. PERFOR	AUTOPSY MED?	rest,	Approximate Interval Betw Onset and D THE North American To Completion of Caust Of Death?
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BY PHYSICIAN: MEDICAL CE	IMMEDIATE CAUSE (Fidisease or condition resulting in death) Sequentially list condition resulting in death) Sequentially list condition resulting in death) CAUSE (Disease or In) that initiated events resulting in death) LA: PART II. Other signific DID TOBACCO L 25. WAS CASE REFERRED EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5	itions, ediete ving ury st ant conditions. Sant conditions are conditions are conditions. JSE CONTO MEDICAL Pending Investigation could not be determined are conditions.	a. DUE TO b. DUE TO c. OUE TO d. OUE TO d. OUE TO A. OUE TO DOBUTE TO CA POSPITAL: 1 Inpatient 2 28e. PLACE Of building, SICIAN: To the best of	(OR AS A COM (OR A	NSEQUENCE OF TEACH OF DEATH YE PLACE OF DEATH YE PLACE OF DEATH INJURY OF DEATH OF D	F): F): In the under TN (Check only) OTHER: 4 Nursing IE OF JURY M 1 street, factory,	one) Home Office	Cause c	ERTAIN SIDENT IN	Part I. 6 Oth 28d. OE 28f. LO	24e. WAS AN PERFOR 1 YES 2' VES CRIBE HOW IN CATION (Street e y or Your, Stete)	AUTOPSY MED? NO NJURY OC	24b CUREO or Atural F	Approximate Interval Betw Onset and Dr. St. No.

32. REGISTRAR'S SIGNATURE

BALTIMORE, MARYLAND 21215-0020

permit. Pages 1, 2, 3 should

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Z4 hours after death. Page 6 may be retained by the hospital or attending physician.	FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-trans		
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PITA	ERAL	within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	
HOS	FUN	With	

95 33736 Amended Item #20b WCHD 10/25/95 mpt STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH October 18, 1995 **OWENS** 8:25 LOUISE WALLER PM 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State or Foreign 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 5. SEX MONTHS DAYS HOURS MIN 1 M 2 X 67 YRS. 221-16-8148 August 31, 1928 Delaware 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY. TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 516 Elberta Ave. Salisbury Wicomico 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? 10e. STATE Wicomico Salisbury Maryland 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 21801 USA 516 Elberta Ave. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE - American Indien, Bleck, White, etc. FORCES? 1 YES 2 NO If yes, specify Cuben, Mexicen, Puerto Rican, etc.)

1 ☐ YES 2 ☑ NO Specify: 1 Never Married 2 X Merried Specify: ВУ 3 Widowed 4 Divorced White COMPLETED 16a, DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade complete Elementary/Secondary (0-12) College (1-4 or 5+) Realtor Real Estate 12 notified at once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Melden Surname) Turpin Waller Alice Horace 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. INFORMANT'S NAME (Type/Print) 2 516 Elberta Ave., Salisbury, MD 21801 Nolan C. Owens 9 20b. PLACE AND DATE OF DISPOSITION (Name of Wicomico DATE Commission of other place)

Parsons Cemetery

Memorial Park 10/21 Salisbury, MD 20a. METHOD OF DISPOSITION
1X Buriel 2 ☐ Cremation 3 ☐ Removal from State 20c. LOCATION — City or Town, State must 4 Donation 6 Other (Specify) examiner 21. SIGNATURE OF FUNCTRAL BERVICE LICENSED 22. NAME AND ADDRESS OF FACILITY Holloway Funeral Home Company 501 Snow Hill Rd., Salisbury, MD 21801 ONTO 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory strest, shock, or heart failure. List only one ceuse on each line. interval Between Onset and Death IMMEDIATE CAUSE (Final the disease or condition Metastatic Breast Cancer 6 years reaulting in death) event, DUE TO (OR AS A CONSEQUENCE OF): other traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events reaulting in death) LAST 6 item 23 shows any injury, PART II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY PERFORMED? PHYSICIAN: MEDICAL 24h. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 TES 2 NO OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO 🗷 UNCERTAIN 🗆 25. WAS CASE REFERRED TO MEDICAL 28, PLACE OF DEATH (Check only one) HOSPITAL 1 TYES 2 NO □ Inpetient 2 □ ER/Outpetient 3 □ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 0 28c. INJURY AT WORK? 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28d. DESCRIBE HOW INJURY OCCURED is marked, 1 Natural 5 Pending ВУ 2 Accident 28e. PLACE OF INJURY — At home, ferm, street, fectory, offica building, etc. (Specify) 3 Sulcide COMPLETED 8 Could not be item 28 4 Homicide determined 29s. CERTIFIER

(Chart role and place, and due to the cause(s) and manner se stated. TO THE HOSPITAL D
TO THE FUNERAL D
De filed within 72 h
IMPORTANT: If is (Check only one) 2 MEDICAL EXAMINER: On the basis of exemination end/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(e) and menner as stated,

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) E. Carroll St., Salisbun E. Mary .n James M.D. . 145 31. DATE FILED (MONTE DEV. Year) 1995 32. APGISTRAP'S SIGNATURE
JULYA D'AUCLEON-RANGEL

n. o.

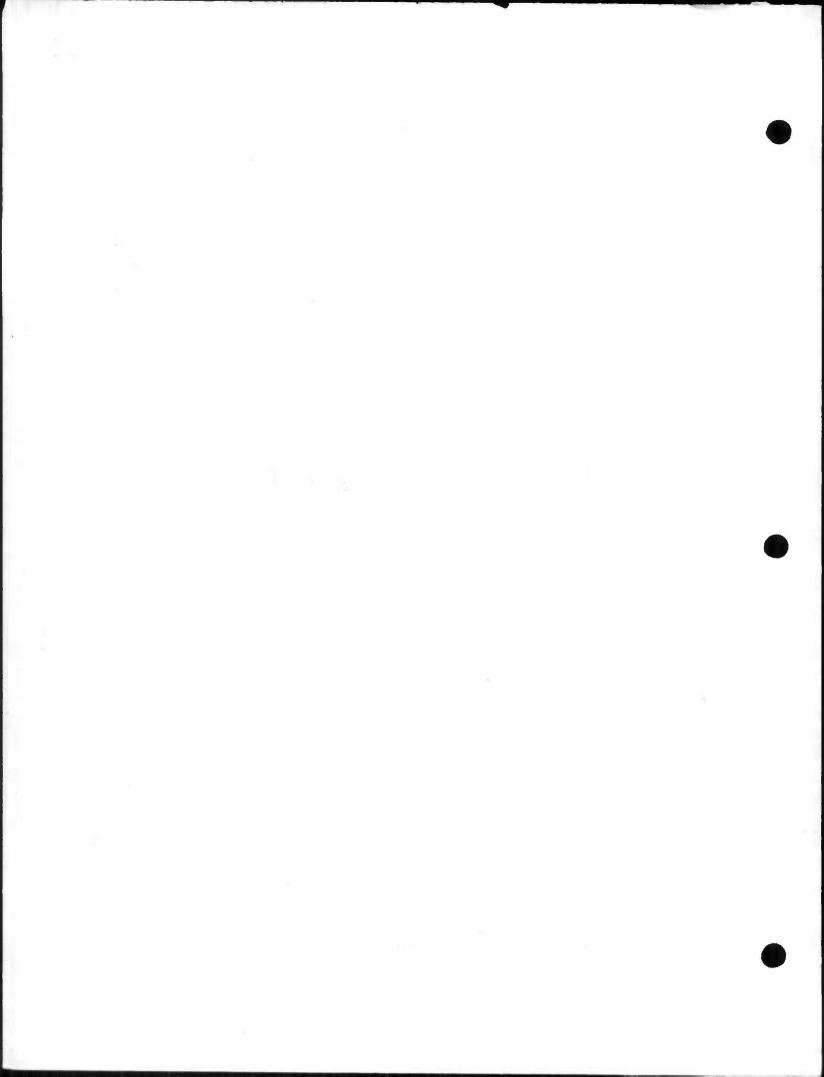
29c. LICENSE NUMBER

030690

29b. SIGNATUME AND LITLE OF CERTIFIER

٤.

29d, DATE SIGNED (Month, Day, Year)



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR 1 - STATE PEGISTRAD

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO.

REGISTRAR			Entil	ICALE	UF	DEA	1 11		HEG. NO			
1. DECEDENT'S NAME (First, Middle, La F. 1 1	en C. Osbo	orne						2. DATE C	D	AY 10	YEAR	3. TIME OF DEATH 4:30 P M
4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. I	land bloth day			- connec		October 20,1995				PLACE (State or Foreign
577-26-0778				MONTHS	DAYS	HOURS	MIN.	June	Day, Year)	1923	Countr	th Carolina
9a. FACILITY NAME (If not institution, gi		9b. CITY	, TOWN	OR LOCATI	ON OF DE	ATH		9c. COU	NTY OF D	TY OF DEATH		
Holy Cross Hospi				Silver Spring				Montgo			gomery	
10a. STATE 10b. COU												10d. INSIDE CITY
	Maryland Montgomery 10e. STREET AND NUMBER					r Sp	_					1 YES 2XXNO
106. STREET AND NUMBER				10	I. ZIP COD						VHAT COUNTRY?	
12312 Charles Ro	12312 Charles Road					20	906			Uni		States
10e. STREET AND NUMBER 12312 Charles Ro 11. MARITAL STATUS 1 Never Merried 2 Merried 3 X Widowed 4 Divorced	1 Never Married 2 Married FORCES? 1 YES				If yes, sp		in, Maxica	n, Puarto Ri	(Specify Ye can, atc.)	s or No—	14. RACE Black Speci	- American Indian, t, White, atc.
15. DECEDENT'S I	TOUGHTION .	1 40.	DEAFDENTIO		00110171		_	1	/// AF DI	A1110001111		WILLCE
(Specify only highest g			DECEDENT'S (Give kind of lile. Do NOT u	work done	during me		ng	160.	KIND OF BU	SINESS/IN	DUSTRY	
Elementary/Secondary (0-12) 12 17. FATHER'S NAME (First, Middle, Last)				make:					Owr	Hom	е	
17. FATHER'S NAME (First, Middle, Last)						18. MOT	HER'S NA	ME (First, M	ddle, Maider	Sumame)		
John Columb	John Columbus Jurney						Cleo	Paxt	on.		ш	
			19b. MAILING	ADDRES	S (Street	and Numbe	r or Rurel I	Route Numbe	r, City or Tov	vn, State, Zi	p Code)	
John M. Osborne			111 S	hipp	ing	Cree	k Ro	ad, S	tever	svil	le,	MD 21666
20a. METHOD OF DISPOSITION 1 X Burlal 2 Cremation 3 7 4 Denation 6 Other (Specify)	20s. METHOD OF DISPOSITION 1 X Burlel 2 Cremetion 3 Removal from State 4 Donation 6 Other (Specify)					cce and date of disposition (Nama of cromatory or other place) October 26, 1995 Rockville						
21. SIGNATURE OF FUNERAL SERVICE	20111	22.	NAME A	ND ADDRE	SS OF FA	CILITY RO	bert	A. P	umph	rev Funeral		
Mucheli	J. J.	ula M	00348		me/F ckvi	lle,	Mar	yland	208	350-2	805	tgómery Ave
IMMEDIATE CAUSE (Final disease or condition resulting in death) Arteriosclerotic Cardiovascular Disease DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):										Onset and Death		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other aignificant conditions.	d									246	. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
										1 TES 2 X NO		
25. WAS CASE REFERRED TO MEDICA			ACE OF DEA				JEI(I) (II	10				
DID TOBACCO USE CO	HOSPITAL:	Xenioutantiant	2 🗆 004	OTHE					40.			
27. MANNER OF DEATH	28a. DATE O		26b. TH			JURY AT	asidence	6 Other	(Specify)	IN HIRV O	CURED	
XIX Netural 5 Pending 2 Accident Investigati	(Month,	Day, Year)		JURY	W	ORK? YES 2	_ NO	200. DES	SHIBE HOW	INJUNT O	CORED	
2 Guilefele	28e. PLACE building	OF INJURY — At 3, atc. (Specify)	home, farm,	street, fed	ctory, offi	ce			TION (Street r Town, State		or Rural	Route Number,
(Orlock Orly)	HYSICIAN: To the best of											s) and manner as stated.
	IFIER		_			29c. LIC	ENSE NU	MBER		29d. DA	TE SIGNED	(Month, Day, Year)
John 2	- Oan	lu		2			0854					r 23, 1995
30. NAME AND ADDRESS OF PERSON					1110	Both	1003-	Mas	culan	d 20	814	
John F. Tauber,				Aven	iue,	betr	iesaa	i, Ma	Lyran	u 20	7014	
31. DATE FILED (Month, Day, Year) OCT 25 199		WAR'S SIGNATURI										
0 100	0											OHMH-16 Rev 1

TO BE COMPLETED BY CHINEBAL DIBERTOR	TO BE COMBIETED BY BUYSICIAN. MEDICAL CERTIFICATION
I examiner must be notified at once.	IMPORTANT: If Nem 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
al.	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
he funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should
or death. Page 6 may be retained by the hospital or attending physician.	TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

FOR STATE REGISTRAR S 1 -

TATE	0F	MARYLAND	/ DEPARTMENT	OF H	EALTH	AND	MENTAL	HYGIENE
		C	ERTIFICATE	OF	DEAT	TH		REG. NO.

	1. DECEDENT'S NAME (First, Middle, Last)	KOW S	1/1		2, DATE OF	DEATH	YEAR	3. TIME OF DEATH				
	1,1232				10	19	95	7:21P M				
		(In yrs. lest birthday) YRS.	MONTHS DAY		7. DATE OF (Month, I	Day, Year)	Count					
		Z THS.				14/63						
oc	9a. FACILITY NAME (If not institution, give street and number)		N OR LOCATION OF		1.5	9c. COUNTY OF DEATH						
DIRECTOR	Holy Cross Hospital	Silve	er Spring		Mo	Montgomery						
EC	10a. STATE 10b. COUNTY	Y, TOWH OR LO	CATION				10d. INSIDE CITY					
8	Maryland Montgomery	Silver	Spring			LIMITS? 1 XYES 2 NO						
	10e. STREET AND NUMBER			101. ZIP CODE		10g. C	ITIZEN OF	WHAT COUNTRY?				
FUNERAL	9709 Glen Avenue			20910			USA					
S	11. MARITAL STATUS 12. WAS DECEDENT EVER	IN U.S. ARMED		ECENDENT OF HISP			14. RAC	E American Indian,				
BY F	1 Never Married 2 Married IF YES, OIVE WAR OR I	DATES		specify Cuben, Mexi- rES 2 NO Spec		an, etc.)	Spec	effy:				
								hite				
TED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	16a. DECEDENT'S	work done during		16b. K	IND OF BUSINESS/I	NOUSTRY					
COMPLET	Elementary/Secondary (0-12) College (1-4 or 5+)	ille. Do NOT u			.,,							
M	12 17. FATHER'S NAME (First, Middle, Last)	Telecom	munica			jax Engi		ng				
						Idle, Maiden Surname		11 1 6 6 9				
BE	Alexander Dzikowski	404 444 946	ADDRESS (Com	et and Number or Run		Lee Fort						
2				venue Si				d 20910				
	Mary Margaret Dzikowski	b. PLACE AND DATE				20c, LOCATION						
	1 XBurial 2 Cremetion 3 Removal from State	meters committee or	ther place)		1							
	4 Donation 5 Donation 5 Other (Specify) Gate of Heaven Cemetery 10/23/95Silver Spring, Maryland 1. SIGNAME AND ADDRESS OF FACILITY											
	11/2/ (1/1/16)			cis J. Co								
	Man Valer	2			4			,MD 20901				
	23. PART I. Enter the diseases, or complications that cause shock, or heart fellure. List only one cause on		not enter the	mode of dying, su	ich as cardis	c or respiratory	arrest,	Approximate interval Between				
	IMMEDIATE CAUSE (Finel											
	resulting in death) a. Cute in the property of the property	nyocerd	il inf	erction				45-14				
	DUE TO (OR AS	A CONSEQUENCE O	PF):									
ON	Sequentially list conditions, Due to (OR AS A CONSEQUENCE OF):											
AT	If any, leading to immediate cause. Enter UNDERLYING											
CERTIFICATION	CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF):											
F	reaulting in death) LAST											
	DART IS ONLY IN INC.											
EDICAL	PART II. Other algorificant conditions contributing to death	but not resulting	in the under	ying cause given i	in Part I. 2	4e. WAS AN AUTOPS PERFORMED?	Y 241	b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE				
ă						YES 2 S NO		OF DEATH?				
M				_				1 TYES 2 NO				
ä	DID TOBACCO USE CONTRIBUTE TO CAUSE (IN X							
SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL:	26. PLACE OF DEA	OTHER:	rre)								
YS	1 Tes 2 NO 1 Inputtent 2 ER/Ou		4 - Nursing i	fome 5 🗆 Residenc	1							
РНУ	27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 1 X Netural 5 Pending		JURY	INJURY AT WORK?	28d. DESC	RIBE HOW INJURY	OCCURED					
BY	2 Accident Investigation	NY 44 harra 44		YES 2 NO	804 1 0043	1004 (Out of a sel bloom	h D	0				
ED	3 Suicide 8 Could not be 4 Homicide detarmined		street, factory, c	эттеа	City or	ION (Street and Num Town, State)	Der of Hural	Houre Number,				
H	AA. CERTIFIER											
APL	Check only 1 CERTIFYINO PHYSICIAN: To the best of my kno							I I A				
COMPLET	2 MEDICAL EXAMINER: On the basis of exemination	ion and/or investigati	on, in my opinio	n, death occured at t	he time, data a	nd place, and due to	the cause	(a) and menner as stated.				
ш	29b. BIGHATURE AND TITLE OF CENTIFIER	77		29c. LICENSE N	UMBER	29d. C	DATE SIONE	D (Month, Day, Year)				
TO B	Mula Hood			0292	93		10/2	2/55				
_	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF C	EATH (ITEM 27) (Type	e, Print)	n 0	1 1	1	10	0.00				
		0313 6	reogiz	. Hre si	Ivers	bul.	10.	20902				
	31. DATE FILED (Month, Day, You) 32. REGISTRAR'S SIG	INATURE										
_	1395 Hally allevellen	Mardall.										

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 15 hours after death. Page 5 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

	REGISTRAR		CERTIF	ICATE OF	DEATH	REG. NO						
1	1. DECEDENT'S NAME (First, Middle, Last) ANNA BELL	PETTIGR	EW			100/01						
9			(In yra. last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Feb. 27,1	8. BIRT	CNPLACE (State or Foreign sitry) St Virginia				
	9e. FACILITY NAME (If not institution, give stree	et and number)		9h CITY TOWN	OR LOCATION OF D		9c. COUNTY OF					
DIRECTOR	Washington County			agerstown		Washington						
1 22	10a. STATE 10b. COUNTY		100 000	V 701101 00 1 00				10d. INSIDE CITY				
	Maryland Washin	ngton	100.01	Hagerstown								
FUNERAL	14809 Hamby Drive			16	2174()	10g. CITIZEN OF WHAT COUNTRY? USA					
BY FUI	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	N U.S. ARMED 2X NO PATES	If yes, s.	CENDENT OF HISPA pecify Cuben, Mexic S 2 NO Specif	NIC ORIGIN? (Specify Yea an, Puerto Rican, etc.) ly:	or No 14. RAC Blac Spe	CE — American Indian, ok, White, etc. chy; White					
E	15. DECEDENT'S EDUCAT (Specify only highest grade co.	TION mpleted)	16a. DECEDENT'S	USUAL OCCUPAT	ION	16b. KIND OF BUS	BINESS/INDUSTRY	wille				
COMPLETED	Elementery/Secondary (0-12)	College (1-4 or 5+)	1	work done during mee retired.) Ses aide		hospi	to1					
\ <u>\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\</u>	17. FATHER'S NAME (First, Middle, Last)	directionit	Har	ses alue								
BE CC	Daniel J. Sensel					ME (First, Middle, Meiden Belle Sta						
10	190. INFORMANT'S NAME (Type/Print) Betty Lee Hamby					Route Number, City or Tow		217/0				
	20e. METHOD OF DISPOSITION	200	PLACE AND DATE	OF DISPOSITION (N	ama of	, Hagersto	CATION — City or T					
	1 Donetion 6 Other (Specify)	al from State Cer	netery, crematory or o Broadfor	oadfording Cemetery 10-19-95 Hagerstown, Marylan								
	21. SIGNATURE OF FUNERAL, SERVICE LICEN	SEE -	0	22. NAME A	ND ADDRESS OF FA	CILITY						
	200011	Menne	ch	415 I	E.Wilson	Blvd. Hage	rstown,M	d. 21740				
	23. PART I. Enter the diseases, or conshock, or heart fellure. Lis IMMEDIATE CAUSE (Final disease or condition resulting in death)	NEUM	ON 14		ode of dying, suc	th aa cardiac or reapl	ratory arreat,	Approximate Interval Batween Onset and Death				
ATION	DUE TO (OR AS A CONSEQUENCE OF): CEREBRO VASCULAR ACCIDENT 6 WKS DUE TO (OR AS A CONSEQUENCE OF):											
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST C. DUE TO (OR AS A CONSEQUENCE OF): d. CONGESTIVE HEART FAILURE 6WES											
	PART II. Other algnificant conditions of	contributing to death t	ut not resulting	le the underlyin								
EDICAL	Suno	- 0	Zm50		g cause given in	Part I. 24a. WAS AN PERFOR 1 TYES 2	MEO?	b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?				
N.	DID TOBACCO USE CONTRIE	BUTE TO CAUSE C	E DEATH VE	S I NO F	T LINICEDTAI		- 1.	1 TYES 2 THO				
A	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEA			141						
SICIA	EXAMINER?	OSPITAL:		OTHER:		Name (News)						
PHY	27. MANNER OF DEATN	28a. DATE OF INJURY	26b. TIM		JURY AT	6 Other (Specify)						
BY PI	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)		URY WO	YES 2 NO	28d. DESCRIBE NOW II	AJURY OCCURED					
8	3 Suicide 8 Could not be determined	25e. PLACE OF INJURY building, etc. (Spec	— At home, farm, a	street, tectory, offic	:0	281. LOCATION (Street e City or Town, State)	nd Number or Rural	Route Number,				
COMPLET	29e. CERTIFIER 1 CHeck only one) 2 MEDICAL EXAMINER: 0	N: To the best of my know						e) and manner se stated.				
	29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUI			D (Month, Day, Year)				
O BE	dia	Dur	m.D	_	D 45		► 10 /	6 95				
10	30. NAME AND ADDRESS OF PERSON WHO C	OMPLETED CAUSE OF DE	ATH (ITEM 27) (Type,	Print) Hal	204 chow	on MD	2170	12				
	31.9717 1º 8 1995 Jak	Witselas Ste	ALL STATES	1	003/07	- 1	1					
. II	ı <i>V</i>	1 /		1.0								

TO THE HOSPITAL, DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Debt. of Health and Mental Holelle prior to burial, cremation, or removal
IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last)
SELBY 2. DATE OF DEATH 3. TIME OF DEATH WILLIAM PURNELL 95AR TONTH 10:40 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 8. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Morith, Dey, Year) DAYS HOURS 220-26-3435 1 X M 2 | F NEWARK, MD. 1916 9e. FACILITY NAME (If not institution, give stre 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH ATLANTIC GENERAL HOSPITAL DIRECTOR BERLIN WORCESTER RESIDENCE OF DECEDENT 10e. STATE 10b. COUNT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MD. WORCESTER BERLIN 1 YES 2 NO FUNERAL 10s. STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 8803 IRONSHIRE ROAD 21811 USA 12. WAS DECEDENT EYER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuben, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married BY 3 Widowed 4 Divorced AR Specify: BLACK 16a. DECEDENT'S USUAL OCCUPATION
(Chan kind of work done during most of working COMPLETED 15. DECEDENT'S EDUCATION secify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY (Sp (Give kind of work done life. Do NOT use retired.) Elementary/Second dary (0-12) College (1-4 or 5+) LABORER SELF-EMPLOYED FARMER 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname) GEORGE A. PURNELL ISABELLA SELBY BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 HELEN PURNELL ADDRESS SAME AS ABOVE 20e: METHOD OF DISPOSITION
1 D Burlel 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State CALVARY UM CH. CEMETERY 4 Donation 5 Other (Specify) 10-24 BERLIN, MD. 21. SIGNATURE OF PUNERAL SERVICE LICENSPE 22. NAME AND ADDRESS OF FACILITY JOLLEY MEMORIAL CHAPEL foretta 1213 JERSEY ROAD, SALISBURY, MD. 21801 23. PART i. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or reapiratory arrest, Approximata ahock, or heart feliure. List only one cause on each line. **IMMEDIATE CAUSE (Final** Onset and Death disease or condition hermonia resulting in death) DUE TO (OR AS A CONSEQUENCE OF): 252 CERTIFICATION Sequentially list conditiona, DUE TO (OR AS A CONSEQUENCE If any, leading to immediate cause. Enter UNDERLYING CUA chimic mnok CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initieted events reaulting in death) LAST PART II. Other algoriticant conditions contributing to death but not reaulting in the underlying cause given in Part I. PHYSICIAN: MEDICAL 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY 1 YES 2 NO OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) 1 YES 2 NO HOSPITAL OTHER: 1 | Inpetient 2 | ER/Outpetient 3 | DOA rising Home 5 - Residence 6 - Other (Specify) 27. MANNER OF DEATH (Month, Day, Year) 28b. TIME OF INJURY 29c. INJURY AT WORK? 26d. DESCRIBE HOW INJURY OCCURED Natural
Accident 5 Pending 1 YES 2 NO M BY vestigatio 28e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 3 Sulcide 28I. LOCATION (Street and Number or Rural Route Number City or Town, State) ETED. 6 Could not be 4 Homicide 29e. CERTIFIER CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end manner ee stated. COMPL 2 ___ MEDICAL_EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner as stated. 29d. DATE SIGNED (Month, Day, Ye 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE Scott WHO DO. 2 30. NAME AND ADDRESS OF PERSON COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

11220

32. REGISTRAR'S SIGNATURE
Julia Danilson Randall

BEAUCIAMPR

31. DATE FILED (Month, Day, Year)

OCT 23 1995

Ur. . 10X 68764 BALTIMORE, MARYLAND 21215-0020 to be executed without after death. Page 6 may be retained by the hospital or attending physic

DIVISION OF VITAL RECORDS, P.O. BOX 68761
OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed without and the control of the con

d by the hospital or attending physician.	id be detached for use as the burial-transit permit. Pages 1, 2, 3 short		fled at once.
death certificate be executed without 24 hours after death. Page 6 may be retained by the hos	er this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlat-transit permit. Pages 1, 2, 3	ith with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	aminer must be not
TO THE HOSPITAL OR ALLENDING PHYSICIAN: The law requires that the death of	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the	be filed within 72 hours after death with the State Dept. of Health and M	IMPORTANT: It item 28 is marked, or item 23 shows any inju

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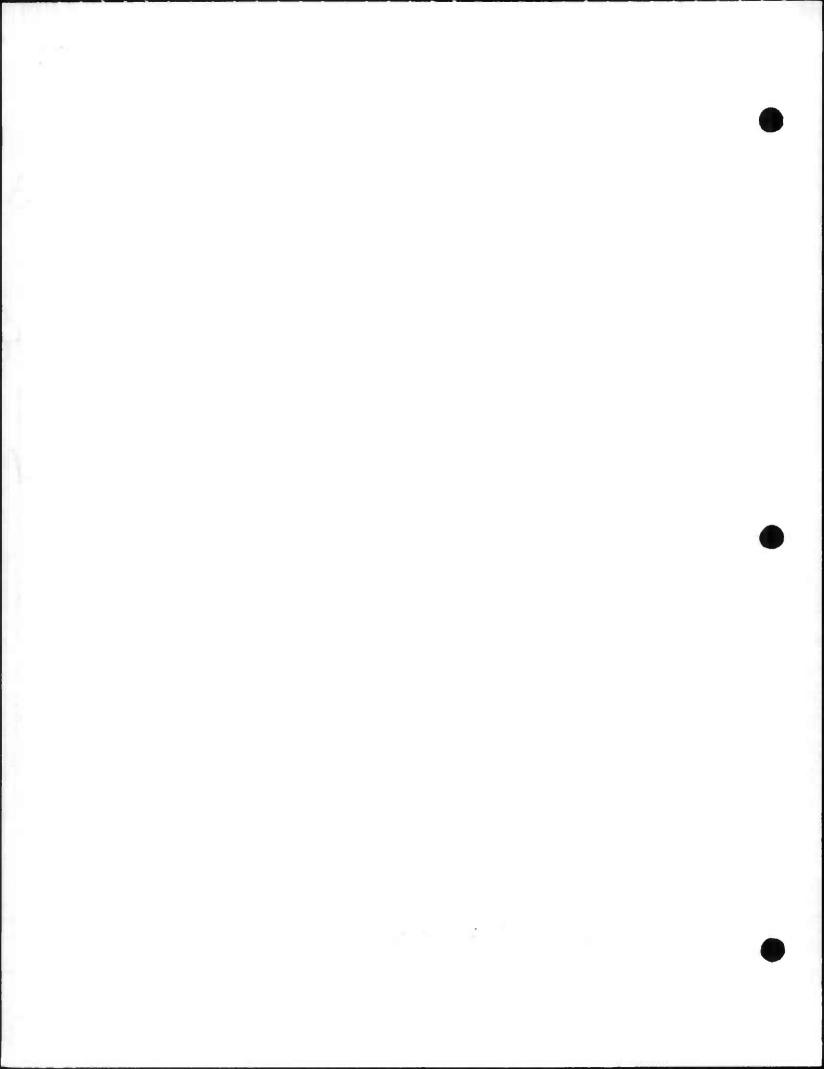
FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH 1, DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF CEATH PLANK EDWARD ALLEN JR. 1995 OCTOBER 17 2:56 Am 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year 6, AGE (In vrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign DAYS HOURS 1 XM 2 - F 28 218-72-4692 August 26, 1967 Maryland 9a. FACILITY NAME (If not institution, give atreet and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF OFATH DIRECTOR PENINSULA REGIONAL HOSPITAL WICOMICO SALISBURY 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION tod. INSIDE CITY Maryland Wicomico Salisbury TES 2 NO FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 610 Cottontail Dr. 21801 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, atc. 1 Never Married 2 X Married If yes, specify Cuban, Maxican, Puerto Rican, etc.) t YES 2 NO Specify Specify: ВУ 3 Widowed 4 Divorced White 8 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working 16b. KIND OF BUSINESS/INDUSTRY COMPLET (Give kind of work done life, Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) 12 4 Police Officer Maryland State Police 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Edward Allen Plank Sr. Sandra Burgan BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Lori E. Plank 610 Cottontail Dr., Salisbury, MD 21801 20e. METHOD OF DISPOSITION
1 [XBurlel 2] Cremellon 3] Re 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State Rehobeth Presbyterian Cemetery 4 Donation 5 Other (Specify) 10/20 Rehobeth, MD 21. SIGNATURE OF FUNERAL SERVICE LICENSES 22. NAME AND ADDRESS OF FACILITY Holloway Funeral Home . 501 Snow Hill Rd., Salisbury, MD 21801 avic 23. PART I. Enler the diseases, or complications their ceuagid the death. Do not enter the mode of dying, such as captisc or respiratory street, shock, or heart feiture. List only one sause on each line. interval Between Oneat and Quath **IMMEDIATE CAUSE (Final** IMME disease or condition JUNSH07 resulting in death) OUE TO (OR AS A CONSEQUENCE OF CERTIFICATION Sequantielly list conditions, DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24b. WERE AUTOPSY FINDINGS 24s. WAS AN AUTOPSY MEDICAL PERFORMED? AWAILABLE PRIOR TO COMPLETION OF CAUSE YES 2 NO 1 XYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO X UNCERTAIN I PHYSICIAN: 26. PLACE OF DEATH (Check only o 25. WAS CASE REFERRED TO MEDICAL HOSPITAL X YES 2 □ NO Inpetient 2X ER/Outpetient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 26c, INJURY AT 28d. DESCRIBE HOW INJURY OCCURED 5 Pending Investigation WORK? 1 Natural 01041 proper В 2 Accident LACE OF NJURY Sulcide 6 Could not be COMPLETED 4 Homicide t CERTIFYING PHYSICIAN ledgs, death occurred at the time, date and place, end due to the cause(s) (Check only one) 2 MEDICAL death occured at the lime, data and place due to the cause(a) and manner ea stated. 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE **DCTOBER 17, 1995** O.C.M.E 2

31. DATE FILED (Month, Day, Year)

OCT 1 9 1995

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		1 - STATE REGISTRAR	STATE OF N	MARYLAN	ND / DEPAR CERTIF					MENTAL HYGIEI REG. NO			
		1. DECEDENT'S NAME (First, Middle, Leal) Briann Lana				1	Par	ker			18,19	YEAR	3. TIME OF DEATH 4:30 PM
_		4. SOCIAL SECURITY NUMBER n/a	5. SEX 1 ☐ M 2 🔀 F	6. AGE (in)	yrs. lest birthday) YRS.	IF UNDER	1 YEAR	IF UNDER	MIN.	7. DATE OF BIRTH (Month, Day, Year) Oct. 18,1		8. BIRTNP Country)	
, 3 should	H H	9a. FACILITY NAME (If not institution, give PENINSULA REGIO		CAL C	ENTER	9b. CITY		LISB	ON OF DE				ATH
es 1, 2,	DIRECTOR	RESIDENCE OF DECEDENT	DENCE OF DECEDENT									10d. INSIDE CITY	
if. Pages		MD W:	icomico		1000		ron				10d. INSIDE LIMITS 1 TYES		
ut permit.	ERAL	10e. STREET AND NUMBER	11 54				101.	ZIP CODE			10g. CITIZEN OF WHAT COUNTRY? United States		
ooko ng physician. he burial-transit	E S	26792 Porter Mi. 11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT FORCES? 1 IF YES, GIVE W	YES :	2 NO		If yes, spe	ENDENT O	n, Mexica	IIC ORIGIN? (Specify Yen, Puerto Rican, atc.)		14. RACE - Black,	American Indian, Whita, atc.
as the	D BY	3 Widowed 4 Divorced						2 (X NO	Specify			Specify:	Black
al or atte	PLETED	Elementary/Secondary (0-12)	(Specify only highest grade completed)				ia. DECEDENT'S USUAL OCCUPATION (Sive kind of work done during most of working like. Do NOT use retired.) 1/a 1/a						
the hospit detached	COMPLI	17. FATHER'S NAME (First, Middle, Last)		,		18. MOTH	ER'S NA	ME (First, Middle, Maide					
# E E	BE	Alfonzo Parker 19a. INFORMANT'S NAME (Type/Print)				122222				nie Jenki			
be retained ge 5 should	5	Alfronzo Parker								Hebron,			
2 2 4		20a, METHOD OF DISPOSITION 1 Description D	oval from State		ACE AND DATE OF						CATION -		n, Stata
Page 1		21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE	/ FIC	. Weste	22.	NAME AN	D ADDRES		HLITY	now H		
after death. Pag by the funeral di moval.		Jew-	Was	te_						son Funera Ext., Sa			ID 21801
within 24 hours upletely filled in cremation, or referent, the med		23. PART I. Enter the diseases, or shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. EXT	zeme	h iine.	mA				n as cardiac or reap	eiratory arr	est,	Approximate interval Between Onset and Dauth
certificate be executing physician and lygiene prior to burn other traumati	ERTIFICATION	Sequantially list conditions, if any, laading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): C. DUE TO (OR AS A CONSEQUENCE OF):											
Me de	O	PART II. Other aignificant condition	ns contributing to	death but	not resulting (n the un	derlying	cause g	iven in i	Part I. 24s. WAS AF	AUTOPSY	24b. W	VERE AUTOPSY FINDINGS
w requires that the state of th	MEDICAL									PERFO		CO	MARLABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
he law has be Dept.	AN:	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL	RIBUTE TO CAL		PLACE OF DEAT			UNC	ERTAIN				
PHYSICIAN: The law this certificate has b with the State Dept.	HYSICI	EXAMINER? 1 YES 2 MHO	HOSPITAL:	ER/Outpatia	ent 3 🗆 DOA	OTHER 4 Num		5 🗆 Res	sidence :	B ☐ Other (Specify)			
DING PHYSIC After this ce death with t	ву рн	27. MANNER OF DEATN 1 Netural 5 Pending 2 Accident Investigation	28a. DATE OF I (Month, Da	ly, Ybar)		M		ES 2	NO NO	28d. DESCRIBE HOW	INJURY OCC	CURED	
TTEN TOR: after	8	3 Suicida 8 Could not be 4 Nomicide datermined	building, a	etc. (Specify)	At home, farm, s					281. LOCATION (Street City or Town, State)		te Number,
글 글 ~ =	COMPLET	29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINE	CIAN: To the best of r	my knowledg	ge, death occurre nd/or investigatio	d at the ti	me, data a	and placa, ath occurs	and dua	to the cause(s) and ma lime, data and placa, a	nner as state	ed. e ceuse(a) a	ind manner ea stated.
TO THE HOSPIT TO THE FUNERA De filed within 7 IMPORTANT: I	TO BE	296. SIGNATURE AND INTERIOR CERTIFIER 296. LICENSE NUMBER 296. LICENSE NUMBER 296. LICENSE NUMBER 296. DATE SIGNED (Month. Day, Year) 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Byron Lee Jennings Phillip Morris Dr., Salisbury; MD 21801 31. DATE FILED (Month. Day, Year) 32. REPETRANCE SIGNATURE									onth. Day. Year) er 18,1995		
	ŕ		nongs	MO	Phillips	Print)	בורץ	Dr.	, 50	alisbury,	MD	218	01
0		OCT 1 9 19	32 HEALTRAN	e sianti	Rendall					/			

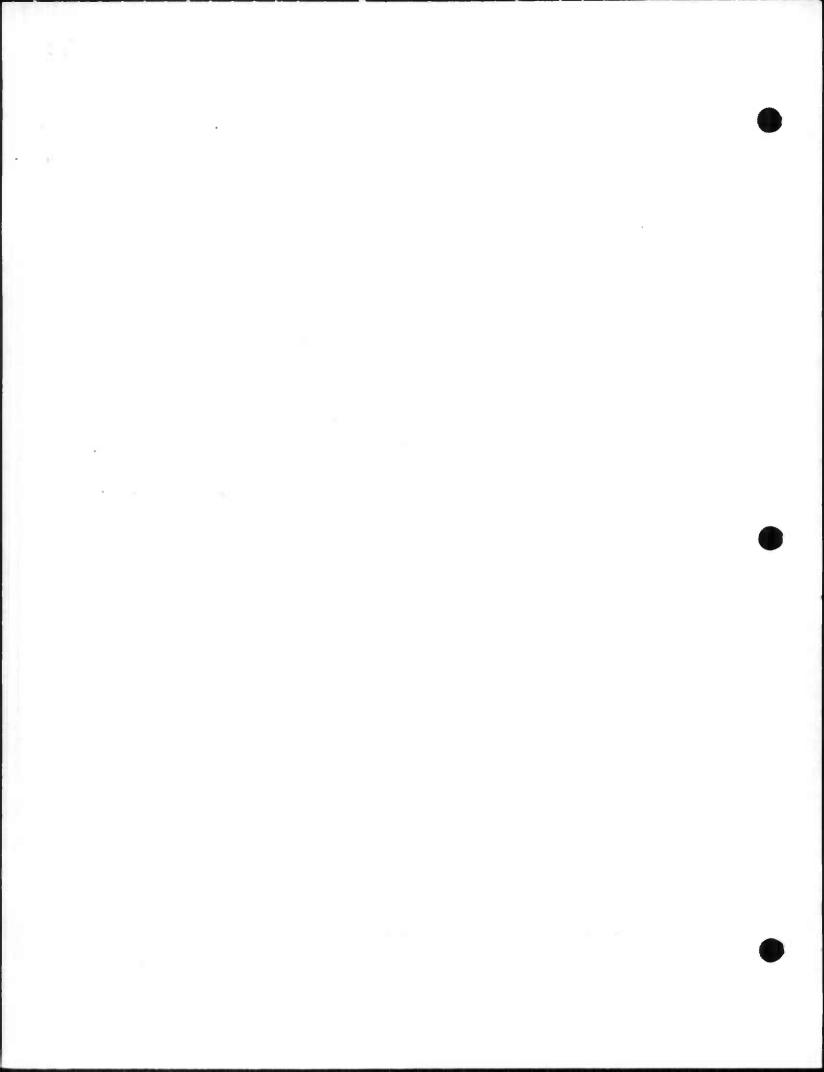


	1 - STATE REGISTRAR		STATE OF I	MARYLAND	O / DEPAR CERTIF	ICAT	OF H	DEA	AND I	MENT	AL HYGIEN REG. NO.	E			
		LISSA	LOU	ISE	PARKEF	?				OCT 14 1995			3. TIME OF DEATH 4:45 A M		
	4. SOCIAL SECURITY NUMBE 217-76-157		5. SEX	8. AGE (In yrs. last birthda		IF UNDER	IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.		7. DATE OF BIRTH (Morith, Day, Year) 2-26-68		a. BIRT	8. BIRTHPLACE (State or Foreign Country) SALISBURY, MD			
E 0	98. FACILITY NAME (If not inst 516 OVER				ALIS		ON OF DE				DEATH				
UINECTOR	MD a	10c. CITY, TOWN OR LOCATION SALISBURY								10d. INSIDE CITY LIMITS? 1 YES 2 X NO					
LONEHAL	104. STREET AND NUMBER 516 0	/ERBRC	OOK DRIVE			ONLI	101	ZIP COD	E				JSA	WHAT COUNTRY?	
5	11. MARITAL STATUS 1 X Never Married 2 A 3 Widowed 4 Divorce		12. WAS DECEDEN FORCES? 1 IF YES, GIVE V	YES 2	ARMED		WAS DEC	ENDENT (OF HISPAN an, Mexican Specify	n, Puerto	IN? (Specify Yes Rican, etc.)				
COMPLEIED	15. DECE (Specify only Elementary/Secondary (0-1		DECEDENT'S (Give kind of a life. Do NOT us PERATO	work done	during mo	st of worki	-	166. KIND OF BUSINESS/INDUSTRY CHILDCARE CENTER			ΕR				
BE CO	17. FATHER'S NAME (First, Mid	ESSE	PARKER					18. MOT	HER'S NAI		Middle, Meiden :		_S		
2	19e. INFORMANT'S NAME (Typ	3/0	PARKER						ABO\		mber, City or Town	Town, State, Zip Code)			
	20a. METHOD OF DISPOSITIO 1 Description 1 Donation 1	3 🗆 Remo		20b. PLA	PRING!	of DISPOS (ber place)	MEM(ne of DRY (GARDE	EN 1	TE 20c. LOC	CATION — HEBRI	City or To	MD .	
	21. SIGNATURE OF FUNERAL	ta	B. Jol	Pers		22.	NAME AN	JER:	SEY F	ROAD	JOLLEY , sali	MEMI SBUR	ORIAI Y, M	CHAPEL D. 21801	
	23. PART I. Enter the dissipance, or her immediate CAUSE (Fins disease or condition resulting in death)	nrt mijure.	a. Acs c	coursed the	ine.	u, i			- 1		FIC:			Approximats interval Between Onset and Death	
	Sequentially list condition if any, isading to immedicause. Enter UNDERLYIN CAUSE (Disease or injury that initiated events resulting in death) LAST	ens, lete	2.	(OR AS A CON		,									
	PERFORMED? AMA							. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?							
	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check conv. con)														
	EXAMINER?	MEDICAL	HOSPITAL:	ER/Outpatient		OTHER 4 Num	R: sing Home	_	sidence	6 Oth	er (Specify)				
	Paperdent	anding vestigation	28s. DATE OF (Month, D.	ny, Ybar)		M	28c. INJU WOI 1 Y	RK? ES 2] NO		SCRIBE HOW IN				
	4 Homicide de	ould not be	building,	F INJURY — At etc. (Specify)	home, farm, s	treet, facti	ory, office			28f. LO	CATION (Street er r or Town, State)	nd Number	or Rural I	Route Number,	
			CIAN: To the best of R: On the bests of sa) and manner as stated.	
	296. SIGNATURE AND VITLE OF	Lin						29c. LICE	ENSE NUM	BER 67	4	29d. DAT	E SIGNED	(Month, Day, Year)	
	30. HAME AND ADDRESS OF PERSON WING COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print) The Cockey, Mrs 100 Power St. Salisbury und 2500.														

17 1995

31. DATE FILEO (Mooils On).

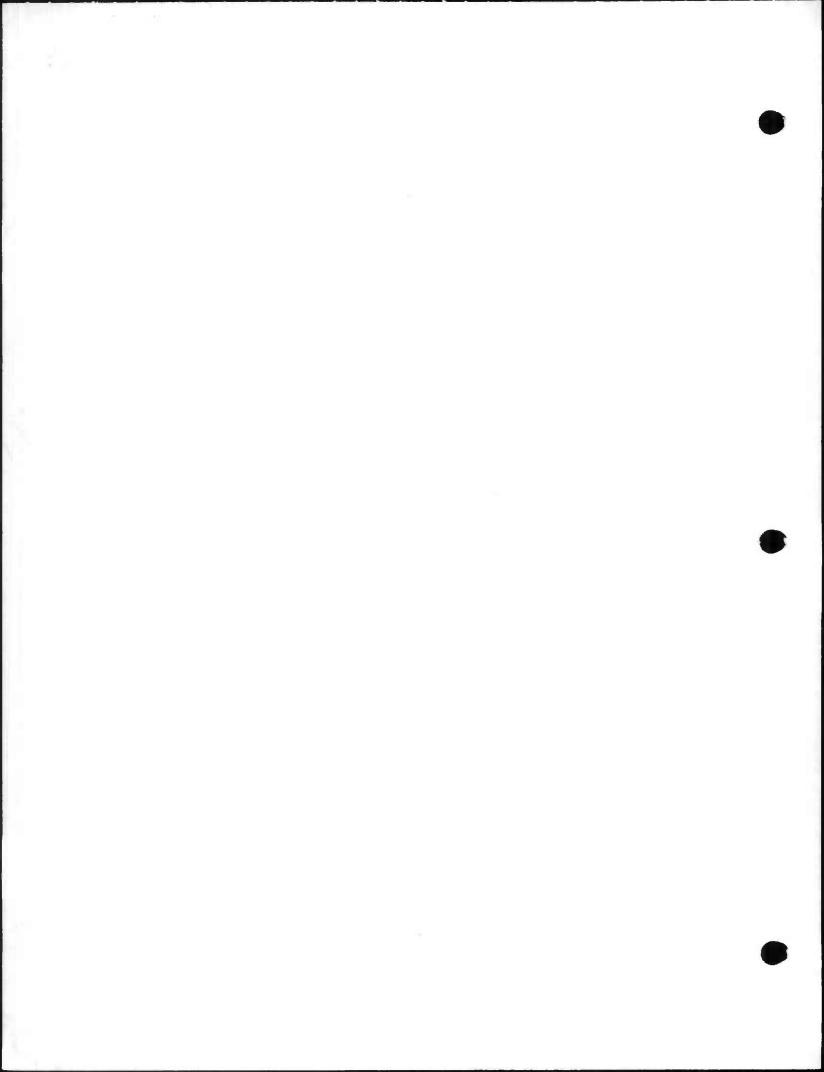
1, M W 1DO /32. APRISTRATION SIGNATURE PARAGELLA



FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO.

1	1. DECEDENT'S NAME (First, I	Viddle, Last)		-			-		DLA		2. DATE OF	DEATH			3. TIME OF DEATH
	KATHERINE		EMMA				- 1	ARS	SONS		Octobe	D		YEAR 995	0940 m
1 }	4. SOCIAL SECURITY NUMBE	R	5. SEX	6. AGE	In yrs. last	birthday)		R 1 YEAR	IF UNDER	24 HRS.	7. DATE OF BIRTH (Month, Day, Year)			0. BIRTI	HPLACE (State or Foreign
	221-10-4311 1□ M 2 및 F 79						MONTHS	NTHS DAYS HOURS MIN. (Month, Day, Year) April 23, 1916				Delaware			
	9a. FACILITY NAME (If not inst		9b. CIT	b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF OE											
B.	PENINSULA REGIONAL MEDICAL CENTER						SALISBURY					WICOMICO			
15	RESIDENCE OF DECEDENT							SALISBURI V					W	VICOMICO	
DIRECTOR		10b. COUNT				t0c. CIT	TTY, TOWN OR LOCATION 10d					10d. INSIDE CITY LIMITS?			
	Maryland	Wic	omico]	Pitt	svil	le						1 YES 2 NO
¥	10e. STREET AND NUMBER						101. ZIP CODE						10g. CIT	IZEN OF	WNAT COUNTRY?
띮	8439 Gumbor	o Rd.					2 1850							USA	A
FUNERAL	11. MARITAL STATUS		12. WAS DECEDEN				13.	WAS DEC	ENOENT C	OF HISPAN	IIC ORIGIN? (S	pecify Yes	or No-	14. RAC	E - American Indian, ck, White, etc.
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8	17. FATHER'S NAME (First, Mid	die, Last)							18. MOT	HER'S NA	ME (First, Middl	le, Maiden	Surname)		
H	Elijah		Collins							nma			ilker		
0	19a. INFORMANT'S NAME (Typ										Poute Number, C				
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1 1	20a. METHOD OF DISPOSITIO t IXI Burlel 2 ☐ Cremation	N 3 □ Rem	noval from Stata		PLACE A				me of		DATE	20c. LO	CATION -	City or To	own, State
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	21. SIGNATURE OF FUNERAL	BENVICE Y	CENSEE				22.	NAME AN	ND ADORE	SS OF FA	neral F				
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\vdash	23. PART I. Enter the dis-	eeses, of	complications the	Venused	the dea	th Do	not enter	the mo	de of dvi	laa eucl	h as cardiac	or social	LISDU	ILY, P.	
	ahock, or hea	art fallure.	List only one cal	ise on e	ech line.	50	iot office		as or uy	mg, auci	it as coluido	or reepi	ratory ar	lear'	Approximate Interval Between
	IMMEDIATE CAUSE (Final disease or condition Onset and Death														
	resulting in death) a. / Consequence or) Due to 108 As A CONSEQUENCE OF)														
_	The registration of Committee or a														
0	Sequentially list conditions, If any, leading to immediate														
CERTIFICATION	cause. Enter UNDERLYIN	G J	('	L-			12.		0 1	_ 5	/				1 dun-
띹	CAUSE (Disease or injury that initiated events		DUE TO	OR AS A	CONSEQU	UENCE O	7	CY 16	7	ar					100
E	resulting in death) LAST		. (0/	T) -		m	1/27	41.	and		1		1 0
		_			×		-	J-16	Set C	1	00.10	m	4		
EDICAL	PART II. Other significant	condition	ns contributing to	death b	ut not re	eulting	in the u	nderlying	g cause o	given in	Part I. 24s	WAS AN		346	MERE AUTOPSY FINDINGS MAILABLE PRIOR TO
[음]	-										10	YES 2	11,300	- 1	COMPLETION OF CAUSE OF DEATH?
WE															1 YES 2 NO
	DID TOBACCO US	E CONT	RIBUTE TO CA	USE O	F DEAT	H YE	S 🗆	NO [UNC	ERTAIN	101				
N N	25. WAS CASE REFERRED TO EXAMINER?	MEDICAL			26. PLACE	OF DEA	TH (Check	only one)							
Sic	1 YES 2 K HO		HOSPITAL:	ER/Outp	atlent 3	DOA	4 Nur		e 5 □ Re	reidence	8 C Other (fip	ecfy)			
PHYSICIAN:	27. MANNER OF DEATH		28s. DATE OF /Month. D			286. TIM		26c. INJ	URY AT		28d. DESCRIE	-	NJURY OC	CURED	
BY F	1 Metural 5 Pe	ending vestigation	Transmitt. 12	alt inact		****	W		res 2	NO					
	a C Suiste	ould not be	26s. PLACE C	F MUJURY etc. (Spec	- At hom	ie, firm, i	street, fac	tory, office			26f, LOCATIO	N (Street a	ind Number	or Plant I	Route Number
TED		dermined	, and a second	meet (Opinio	-90						City or To	wrt, State)			All Constants
COMPLET	29a. CERTIFIER 1 CERTIF	YING PHYS	ICIAN: To the beat of	my knowl	edge des	th accum	ad at the t	time date	and place	and due	to the enumeral				
X															a) and menner as stated.
	296. SIGNATURE AND TITLE O						, my (provd, dit			
B	290. SIGNATURE AND TITLE D	nt a	17 11						1	NSE NUN					(Month, Day, Year)
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			Cruncy	1 3-0	CLIST	37.	مالار	SOUP	-411	rid,	2180	1			
	31. DATE FILED (Month, Day, 16 OCT 17		ST BEGISTRA	THE SIGN	- Rard	ell									
	UU I IL (1333	17												



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FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

3. TIME OF DEATH

REG. NO

retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020 hours after death. Page 6 may be

BOX 6876 executed RECORDS, P.O. DIVISION OF VITAL

2. DATE OF DEATH VEAR PATTERSON DONALD PHILIP AM OCTOBER 995 10:50 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTN (Month, Day, Year) 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTNPLACE (State or Foreign DAYS HOURS 1 XM 2 F 54 217-36-1025 YAS. January 24, 1941 Maryland Pages 1, 2, 3 should 9s. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN DR LOCATION OF DEATH 9c. COUNTY OF DEATH SALISBURY WIComico DIRECTOR 1704 CAMDEN AVE RESIDENCE OF DECEDENT 19c CITY TOWN OR LOCATION 10a. STATE 10b. COUNT 10d. INSIDE CITY Maryland Wicomico Salisbury 1 XYES 2 ND permit. 10a. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 1703 Carver Square 21801 USA use as the burial-transit 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No-if yes, specify Cuben, Maxican, Puerlo Rican, etc.) 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 X Married 1 YES 2 K NO Specify: Specify: BY 3 Widowed 4 Divorced White ETED. 15. DECEDENT'S EDUCATION 18s. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Spec Elementary/Secondary (0-12) College (1-4 or 5+) detached for COMPL 12 Construction Contractor once. 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Meiden Surname, 9 76 Harry Alton Patterson Sr. Viola Irene Carver BE director, page 5 should notified 19s. INFORMANT'S NAME (Type/Print) 19b. MAILIND ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code, 5 Elaine H. Patterson 1703 Carver Square, Salisbury, MD 21801 be 20s. METNOD OF DISPOSITION
1 XBuriel 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must 4 Donation 5 Other (Opecify) Parsons Cemetery 10/16 Salisbury, MD examiner AL SERVICE LICENSE 22. NAME AND ADDRESS OF FACILITY funeral Holloway Funeral Home GUZE 501 Snow Hill Rd., Salisbury, MD 21801 filled in by the four ion, or removal, medical /23. PANY I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiretory arrest, ahock, or heart failure. List only one cause on agent line. Interval Between **Onset and Death** MMEDIATE CAUSE (Final the cremation. disease or condition_ OUTACT GUNSHOT WOUND OF CHEST completely resulting in death) event, DUE TO (OR AS A CONSEDUENCE OF): in and com to burial, o traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEDUENCE OF): e attending physician a lental Hygiene prior to If any, leading to immediate cause. Enter UNDERLYING OR ATTENDING PHYSICIAN: The law requires that the death certificate be CAUSE (Diseasa or Injury other DUE TO (OR AS A CONSEDUENCE OF): that initiated events resulting in death) LAST 0 the atten Injury, PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL and and PERFORMED? AVAILABLE PRIOR TO amy Signed t COMPLETION OF CAUSE 1 YES 2 NO shows 1 YES 2 ND been s DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO Y UNCERTAIN I PHYSICIAN: has by Dept. 23 26. PLACE DF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL this certificate his with the State D irked, or Item HOSPITAL : 1 X YES 2 | NO ☐ Inpetient 2 ☐ ER/Outpetient 3 ☐ DOA 4 Nursing Home 5X Residence 6 Other (Specify) 28s. DATE OF INJURY (Month, Day, Year) 286. TIME DE INJURY IO 20 M 28c. INJURY AT WORK? 27. MANNER OF DEATH 26d. DESCRIBE NOW INJURY OCCURED marked, 5 Pending Investigation 1 Netural SUMSIEUT SHOT SELF 1 YES 2 ND 10 12 95 BY DIRECTOR: After the 2 Accident
3 Suicide 28s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number 69 MD COMPLETED 6 Could not be 4 Nomicide 200 CAMDENAUE WICOMILOCO 1704 item 29s. CERTIFIER

(Chack only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. TO THE HOSPITAL TO THE FUNERAL C be filed within 72 h (Check only one) ** MEDICAL EXAMINER: On the besis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. SIGNATURE AND TITLE OF CERTIFIE 29d. DATE SIGNED (Month, Day, Year) LICENSE NUMBER B Breitfull O.C.M.E te OCTOBER 13, 1995 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 HARAPRIM A. KORELL MO 31. DATE FILED (Month, Day, Year)
OCT 1 7 1995 32 AEGISTHAR'S SIGNATURO 20

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

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DIVISION OF VITAL RECORDS, P.O. BOX 68760	Warrich
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH Panos Oct. 1995 18 9:48 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 7. DATE OF BIRTN (Month, Day, Year) IF UNDER 1 YEAR IF UNDER 24 HRS. BIRTHPLACE (State or Foreign Country) 1 M 2 F DAYS HOURS MIN. YRS. 224-28-6917 23 Aug 1908 Tenn. permit, Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATN 9c, COUNTY OF DEATH DIRECTOR Anne Arundel Med. Ctr. Annapolis Anne Arundel 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MD Anne Arundel Arnold 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 101, ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? the burial-transit College Parkway 21012 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES7 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuben, Mexican, Puerto Rican, stc.)

1 YES 2 NO Specify: Specify: Specify: 1 Never Merried 2 Married BY 3 Widowed 4 Divorced White 35 COMPLETED 16e. OECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION use 16b. KIND OF BUSINESS/INDUSTRY (Spe 100 College (1-4 or 5+) detached Homemaker Home once. 17. FATHER'S NAME (First, Middle, Last) 16. MOTNER'S NAME (First, Middle, Meiden Surname) 2 BE J. Gregory Mary Harrison page 5 should notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Virgal Brewster 540 Cypress Lane Severna Park, MD. 21146 99 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION — City or Town, State must 1 Burlei 2 Cremation 3 Removal from State funeral director, Lakemont Cem. 10/23 4 □ Donation to Other (Specify) Entombment Davidsonville, MD 21. SIGNATURE OF FUNERAL SE examiner 22. NAME AND ADDRESS OF FACILITY Barranco & Sons Funeral Home in by the f ann Severna Park. MD. 21146 medical 23. PART/. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Approximata ahock, or heart fellure. List only one cause on each lina. completely filled in rial, cremation, or r interval Between IMMEDIATE CAUSE (Finel Onset and Death disease or condition the Mitatohi acidono Possible Sepsis resulting in death) event, DUE TO (OR AS A CONSEQUENCE OF) an and com to burial, u traumatic CERTIFICATION Sequentially list conditions. OUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate attending physician mtal Hygiene prior to cause. Enter UNDERLYING CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 the atter PART II. Other algorithms conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO signed by the Health and N atheroschistic cardiovarula shows any COMPLETION OF CAUSE 1 YES 2 NO OF OFATH? 1 YES 2 NO t, of I DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\Boxed{1}\) NO \(\overline{\overline{\text{W}}}\) UNCERTAIN \(\Boxed{1}\) has be Dept. PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF OEATH (Check only one) Hem EXAMINER? certificate the State HOSPITAL:
1 | Inpstient 2 | ER/Outpatient 3 | DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) marked, or 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT 28d. OESCRIBE HOW INJURY OCCURED this (1 Natural 2 Accident 5 Pending BY 1 YES 2 NO After 1 Investigation TO THE HOSPITAL OR ATTENDING TO THE FUNERAL DIRECTOR: After be filed within 72 hours after deal IMPORTANT: If item 28 is m 28e. PLACE OF INJURY — At home, term, street, factory, office building, stc. (Specify) 3 Suicide 8 Could not be 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 4 Nomicide determined 29e. CERTIFIER (Check only one)

2 MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) and manner ee stated. 2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(e) end manner ee stated. 29b. SIGNATURE AND TITLE OF CERTIFIER

Eden, MO

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30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

EDEN

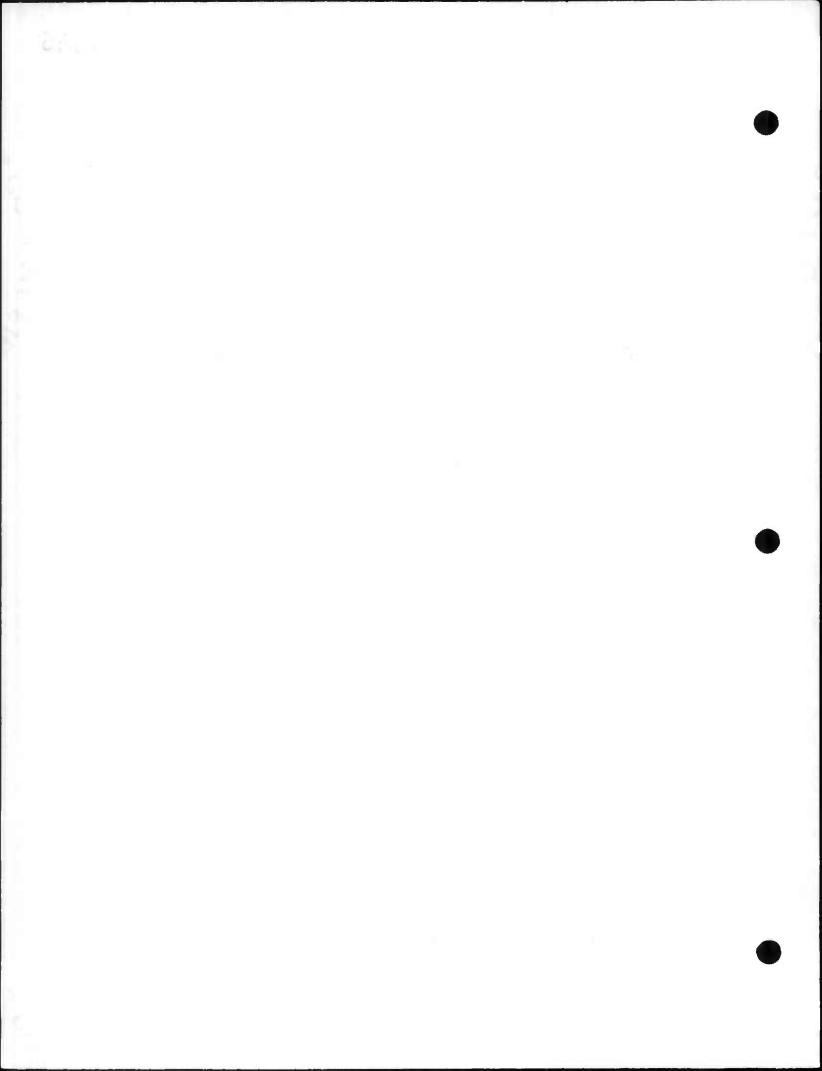
29c. LICENSE NUMBER

RIDGELY AVE, ANNAPOLIS, MD 2/401

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29d. DATE SIGNEO (Mpnth, Day, Year)

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DHMH-18 Rev 1/89

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 . STATE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

		HEGISTRAH				OF DEATH	REG. NO.			
		1. DECEDENT'S NAME (FIRST, MIDDING, Last)	- / -	- PET 10	Ay		2. DATE OF DEATH DATE	30 9	3. TIME OF DEATH 3. TIME OF DEATH M	
pin		4. SOCIAL SECURITY NUMBER 213-48-4731 Ba. FACILITY NAME (If not institution, give str	10 M 2 PF 10	YRS.	IF UNDER 1 YE	YS HOURS MIN.		94 F	BIRTHPLACE (State or Foreign Country) Pennsylvania	
prysidati. burial-transit permit. Pages 1, 2, 3 should	TOR	Meridian Health Ca				napolis	ATH	Anne Arundel		
t. Pages	FUNERAL DIRECTOR	MD Anne A	Arundel		Annap			10d. INSIDE CITY LIMITS? N∑ YES 2 □ NO		
nsit perm		106. STREET AND NUMBER 2 Sampson Place			4,110,10	10f. ZIP CODE 21401		10g. CITIZEN OF WHAT COUNTRY? United States		
	BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U. FORCES? 1 \(\text{YES} \) YES : IF YES, GIVE WAR OR DATE		If yes			Yes or No- 14, RACE - American Indian.		
ital or attending I for use as the	LETED	15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12)			ork done during retired.)	PATION g most of working	16b. KIND OF BUS	SINESS/INDUS		
the hospital or detached for once.	COMPL	12 17. FATHER'S NAME (First, Middle, Lest)		House	wife			Home		
by the be der		Frederick H. Sha	13.4				ME (First, Middle, Maiden	Sumame)		
5 should notified	BE	19a. INFORMANT'S NAME (Type/Print)	.vv	19b. MAILING	ADDRESS /Str		a Marsden Toute Number, City or Town	e Chair Zin Co		
	6	Leonard Z. Bulma	n				er St. Anna			
		20a. METHOD OF DISPOSITION 1	val from State 20b. Pt.	ACE AND DATE OF	FDISPOSITION	N/Name of	y 11/3/95	CATION - CIN	or Town State	
nours arer death. Page 6 may be in by the funeral director, pa or removal. medical examiner must b		21. SIGNATURE OF FUNERAL SERVICE LICE	Hullio	ym\	22. NAM	E AND ADDRESS OF FA	John M.	Tay Ior	Funeral Home	
TO THE INDEPTIAL UN A LENDING PRISICIAN: THE LAW REQUIRES THAT THE CHARLORE DE EXECUTED WITHOUTS After 10 THE FUNEFAL UNFETDRE. After this certificate has been signed by the attending physician and completely filled in by the 1 field within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical especially.	CERTIFICATION	23. PART i. Enter the diseases, or conshock, or heart fellure. L. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	ist only one cause on each	PIR PIR PIR PIR PIR PIR PIR PIR PIR PIR	ATT IA		AR ACC		Interval Between	
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certific certific the	PHYS	27. MANNER OF DEATH	1 Inpetient 2 ER/Outpatie	28b. TIME		Home 5 Residence	8 Other (Specify) 28d, DESCRIBE HOW II	HIEV OCCUR	en .	
After this seath with marked	ВУР	1 Netural 5 Pending 2 Accident Investigation	(Month, Day, Year) 28a. PLACE OF INJURY —	INJU	RY 1	WORK?				
DIRECTOR: John 28 is	ETED	3 Suicide 8 Could not be determined	building, etc. (Specify)	At nome, rarm, ser	eet, tactory, t	mica	281. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
UNERAL DI rithin 72 ho	COMPLET		AN: To the bast of my knowledge. On the basis of examination and						Puse(a) and mariner as stated.	
TO THE F De filed w	TO BE	29b. SIGNATURE AND TITLE OF CERTIFUER	Del ent	am		29c. LICENSE NUM	BER 38	29d. DATE SI	GNED (Month, Day Year)	
		30. NAME AND ADDRESS OF PERSON WHO MICHAEL J. LA	entra un	(ITEM 27) (Typo, E	(1) G.	ELY ALE	STE 120	ANNI	Molis Md 2140/	
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DIVISION OF VITAL RECORDS, P.O. BOX 68760.

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	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, ps be filed within 72 hours after death with the State Dept. of Health and Memal Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must it
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH YEAR Edward George Post Oct 1995 3:50 8. BIRTHPLACE (State or Foreign Country) 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 1 YEAR IF UNDER 24 HRS. DAYS HOURS MANA 1 M 2 - F 547-60-7756 Dec/16/1932 Pennsylvania 9s. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH Manor Care Nursing Center DIRECTOR Potomac Montgomery RESIDENCE OF DECEDENT 10a STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MD Montgomery Silver Spring t TYES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 13828 Castle Avenue #202 20904 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—It yes, specify Cuban, Mexican, Puarto Rican, etc.) 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO IF YES, GIVE WAR OR DATES 14. RACE - American indian, Black, White, etc. 1 Never Married 2 Merried 1 TES 2 NO BY Specify 3 Widowed 4 Divorced white 1953-Unknown COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) 12 Unemployed None once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) 7 George Post Jane Eva Hoten pellilled 19e. INFORMANT'S NAME (Type/Print) 19b, MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Ernest J Higgins 1817 Franklin St NE, Washington D.C. 20018 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State cemetery, crematory or other place)
Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 10/25 Alexandria VA 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Advent Funeral & Cremation Services Annapolis MD 21401 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failure. List only one cause on each line. Approximata Interval Between Onset and Death IMMEDIATE CAUSE (Fine) disease or condition___ Carelin reaulting in death) DUE TO (OR AS A CONSEQUENCE OF) Carmonale CERTIFICATION Sequentially list conditiona, DUE TO JOB AS If any, leading to immediate cause. Enter UNDERLYING mome with DUE TO (08) AS CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. PHYSICIAN: MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE 1 - YES 2 0 NO 1 TYES 2 T NO 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) OTHER 1 YES 2 NO 1 | Inpatient 2 | ER/Outpatient 2 | DOA 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending Investigation 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) ETED 6 Could not be 4 Homicide COMPLI 1 CERTIFYING PHYSICIAN: To the best of my kno wiedge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER OF occured at the time, data and place, end due to 296. SIGNATURE AND PITTLE OF 0 2 Elliot dstein 00

32. REGISTRAR'S SIGNATUR

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	FOR STATE REGISTRAR	STATI	OF MARYL	AND / DEPA	RTMEN	OF H	IEALTH AND I	MENTA	L HYGIEN REG. NO.	E			
	1. OECEDENT'S NAME (First, Min Pier P	ntoin 4	8. AGE	Polli (In yrs. last birthda)	OT UNDER	J 1 YEAR	R. IF UNDER 24 HRS.	MONT 7. DATE	ember of BIRTH	1 199	BIRTHPLA	TIME OF OEATH O 1 4 4 Am ACE (State or Foreign	
	162-42-5998 9a. FACULTY NAME (If not institu	tion, give street and nu		45 YRS.	9b. CITY	, TOWN C	HOURS MIN.		28,19	49 W		NGTON, D.C.	
ECTOR	SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE MONTGOMER									RY			
PIR	MARYLAND	MONTGOMER	Y		10c. CITY, TOWN OR LOCATION GAITHERSBURG						tod. INSIC LIMIT t XYES		
ERAL	36 DALAMAR	STREET			101. ZIP CODE 20877						UNITED STATES		
BY FUN	11. MARITAL STATUS 1 Never Married 2 Ma 3 Widowed 4 Divorce	rried FORC	DECEDENT EVER ES? 1 YES B, GIVE WAR OR (2 XNO		If yes, sp	CENDENT OF HISPAI ecity Cuben, Mexica 2 NO Specif	in, Puerto		or No — 14	Black, W	American Indian, Inite, etc.	
APLETED	15. DECEDI (Specify only his Elementary/Secondary (0-12)	(Give kind o	DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working the Do NOT use retired.) STAURANT OWNER RESTAURANT										
BE COMPL	17. FATHER'S NAME (First, Middle PIERRE				18. MOTHER'S NA HELEN		BOWEN						
101	198. INFORMANT'S NAME (Type/Print) PAMELA A. POLLET 19b. MAILING AODRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2480 16 ST. N.W. #217 WASHINGTON, D.C. 20009										20009		
	20a. METHOD OF DISPOSITION 1 Burlai 2 Cramation 3 Removal from Stata 4 Donation 5 Other (Specify) Donation 5												
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE, Barber 22. NAME AND ADDRESS OF FACILITY MURIEL H. BARBER FUNERAL HOME 20882 P.O. BOX 5038 LAYTONSVILLE, MARYLAND												
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF):										ι,	Approximate Interval Between Onset and Death 3 MA.	
ERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): d.												
EDICAL C	PART II. Other algnificant		but not resultin						24s. WAS AN AUTOPSY PERFORMED? t YES 2 NO		ERE AUTOPSY FINDINGS AILABLE PRIOR TO OMPLETION OF CAUSE F DEATH?		
AN: M	DID TOBACCO USE 25. WAS CASE REFERRED TO N		TO CAUSE (OF DEATH				N 🗆			, ,	□ YES 2 NO	
PHYSICIAN:	EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH	HOSPI 1 Mulipa	tlant 2 ER/Out	tpetlant 3 🗆 DOA	OTHE 4 Nu	R: rsing Hon	ne 5 🗆 Raaldence						
BY PH	1 Petersel 5 Per	nding eatigation	DATE OF INJURY (Month, Day, Year)		IME OF INJURY M	1 🗌	JURY AT ORK? YES 2 NO	28d, DE	SCRIBE HOW I	NJURY OCCUP	RED		
ETED		uld not be armined	PLACE OF INJUR building, atc. (Spe	IY — At home, farr ec/fy)	n, street, fac	tory, offic	ca .		CATION (Street in or Town, State)		Rural Rout	e Number,	
COMPL	0001	L EXAMINER: On the										nd manner as stated.	
TO BE	294 SIGNATURE AND TITLE OF	STO.					29c. LICENSE NU D 296	75	5	29d. DATE S	IGNED (M	onth, Day, Year)	
	RAULA BO	CCIA, M	10 97	707 m	rpe, Print)	1	CONTER	- D	#30	no Re	٥٤١٤١	Ville	
	31. DATE FILED (Month, Day, Yea	32.	REGISTRAR'S SIG	A									
	MANAR	100										DHMH-16 Rev 1/89	

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BALTIMORE, MARYLAND 21215-0020	tained by the hospital or attending physics
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DIVISION OF VITAL RECORDS,

nospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transif permit. Panes 1.		ස්
leath. Page 6 may be retained by th	funeral director, page 5 should be d		xaminer must be notified at o
be executed with	ician and completely filled in by the	ior to burial, cremation, or removal.	raumatic event, the medical ex
w requires that the death certificate	been signed by the attending phys	pt. of Health and Mental Hygiene pr	3 shows any injury, or other t
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with. Nours after death. Page 6 may be retained by the hospital or attending physician.	THE FUNERAL DIRECTOR: After this certificate has	be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE REGISTRAR	STATE OF MARYLA	ND / DEPART CERTIFIC	MENT OF H	EALTH AND I	MENTAL HYGIEN				
	1. DECEDENT'S NAME (First, Middle, Last)	SUNG HA				2. DATE OF DEATH	AV VEAR	3. TIME OF DEATH 12:50 AM M		
	4. SOCIAL SECURITY NUMBER 216-80-3020	1 M 2 D F 9	3 YRS.	IF UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN. PR LOCATION OF DE	7. DATE OF BIRTH (Month, Day, Year) Feb. 17,1	B. BIRTNPLACE (State or Foreign Country)			
BO BO	98. FACILITY NAME (If not institution, give s Lorien Nursing Ho	9c. COUNTY OF HOWAR	OUNTY OF DEATH							
5	RESIDENCE OF DECEDENT 10a, STATE 10b, COUNT									
DIRECTOR	Maryland Ho	oward	1	icott (10d, INSIDE CITY LIMITS? 1 TYES 2 NO		
FUNERAL	10e. STREET AND NUMBER			101	ZIP CODE			WHAT COUNTRY?		
NEI	3600 Horned Owl (21042			States		
BY	1 Never Married 2 Married 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2 XNO	II yes, sp	ENDENT OF HISPAN ecify Cuben, Mexical 2 NO Specify	IIC ORIGIN? (Specify Yea n, Puarto Rican, atc.)	a or No— 14. RACE — American Indian, Black, White, atc. Specify: Asian			
COMPLETED	15, DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	CATION s completed) College (1-4 or 5+)	18a. DECEDENT'S US (Give kind of wor life. Do NOT use	rk done durina mo	N st of working	16b, KIND OF BUS	SINESS/INDUSTRY	20201		
IPL	12	College (I-4 Of 5+)	None			Non	ne			
ON	17. FATNER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Middle, Maiden				
BE (Ik Duk Peal				unkno	wn				
TO B	19a. INFORMANT'S NAME (Type/Print)		19b. MAILINO A	DDRESS (Street a	nd Number or Rural F	Route Number, City or Tow	n, State, Zip Code)			
-	Yoo I. Peal		3600 Hc	rned Ov	1 Court	Ellicott	City, M	21042		
	20a. METNOD OF DISPOSITION 1 M Burlat 2 Cremation 3 M Ramoval from Stata 4 Donation 5 Other (Specify) 20b. PLACE AND DATE Of DISPOSITION (Name of camalery, crematory or other place) Flushing Cemetery 10-27 Flushing, NY									
	21. SIGNATURE OF FUNERAL SERVICE LIG		rability C	22, NAME AN	D ADDRESS OF FAC	CILITY				
	> Sperna.	Collins				ke Funera mbia Pike		Inc. City21043		
	23. PART i. Enter the diseassa, or shock, or heart fellura.	complications that caused List only one cause on sa	ths desth. Do not	snter the mo	ds of dying, such	n as cardiac or respi	ratory arreat,	Approximata Interval Between		
	iMMEDIATE CAUSE (Final disease or condition reaulting in death) a. Graph grene of foot But TO (OR AS A CONSEQUENCE OF):									
Z	Oi sentes mullitus									
ATIC	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING Attures Classific Earlier Earlier Course Ly									
CERTIFICATION	CAUSE (Disease or Injury that Initisted events resulting in death) LAST									
	d									
MEDICAL	PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 24 NO COMPLETION OF CAUSE OF DEATH?									
Σ	DID TOBACCO USE CONT	DIRLITE TO CALISE OF	DEATH VEC		- LINICEDTAIN			1 Tes 2 No		
NA	25. WAS CASE REFERRED TO MEDICAL		6. PLACE OF DEATH		UNCERIAIN	4 L]				
SIC	EXAMINER?	HOSPITAL: 1 Inpatient 2 ER/Oulpa	C	THER:	5 Residence	6 C Otton (Orange)				
PHYSICIAN:	27. MANNER OF DEATN 1 Natural 5 Pending	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME C	OF 28c, INJU	JRY AT	28d. DESCRIBE NOW II	NJURY OCCURED			
D BY	2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJURY - building, etc. (Specif	At home, farm, stre		ES 2 NO	281. LOCATION (Street a City or Town, State)	nd Number or Rural	Route Number,		
LETE		CIANI To the boat of my boat					·			
COMPLETED		CIAN: To the best of my knowle						s) and manner as stated.		
BE C	29b. SIGNATURE AND THE OF STREET				29c. LICENSE NUM		29d. DATE SIGNED	(Month, Day, Year)		
2	30. NAME AND ADDRESS OF PERSON WN	O COMPLETED CAUSE OF DEA	TN (ITEM 27) /Turns Pr	int)	weed	<i>y</i> •	- UCI disc	24,1995		
	VERRY In Law	- 10 col 12 mo	55 Litt	Le Paru	-ENT A	Colembra,	ma 20	044		
	31. DATE FILED (Month, Day, Year) OCT 2 6 1995	P. REGISTRAR'S SIGNA								

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attending physician. se as the burial-transit permit. Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within exthours after death. Page 6 may be retained by the hospital or :	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for us be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT. If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 . STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR				CERTIF	ICATE O	DEATH		REG. NO					
	1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH DAY YEAR MONTH DAY YEAR													
DIRECTOR	JAIMANGAL		PERS	AUD				Oct.	25,	" 1 99	5	8:40	A	М
	4. SOCIAL SECURITY NUMBER				last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS		OF BIRTH		8. BIRTH	IPLACE (State or	Foreign	
	None		X M 2 F	75	YAS.	MONTHS DAYS	HOUNS MIN		27, 192	20		yana		
	Se. FACILITY NAME (If not institution					96. CITY, TOWN	OR LOCATION OF	DEATH		9c. COUNTY OF DEATH				
	Holy Cross Hos		1			Silve	r Spring	1		Montgomery				
딦	RESIDENCE OF DECEDER	OUNTY			ton CIT	Y, TOWN OR LOC	ATION							
<u>E</u>		100.00										10d. INSIDE C	TY	
	Guyana N. Cummingsburg				06	orgetow						1 YES 2)		
FUNERAL] '	101. ZIP CODE			10g. CITIZEN OF WHAT COUNTY			7					
2	231 Middle Street 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED					None			Guyana					
	1 Never Married 2 Married FORCES? 1 YES			YES 2	2 X NO If yes, specify Cuben, Maxic			icen, Puerto i					dlan,	
BY	3 Wildowed 4 Divorced IF YES, GIVE WAR OR DATES					1 🗆 YE			Spec	t India				
	15. DECEDENT	S EDUCAT	ION	18a.	DECEDENT'S	USUAL OCCUPAT	TON	186	KIND OF BUI	SINESS/INI	_	C THUTE	111	_
	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)			-	(Give kind of work done during most of working life. Do NOT use retired.)				19b. KIND OF BUSINESS/INDUSTRY					
립	12		(1-4 of 5 +)	Self employed			d Farmi			nα				
COMPLETED	17. FATHER'S NAME (First, Middle, La	est)					18. MOTHER'S							-
BE C	Unavailable						Unavai			,				
8	19a. INFORMANT'S NAME (Type/Prin	1)			19b. MAILING	ADDRESS (Street	and Number or Rur			n, State, Zic	Code)			\dashv
٩	Benny Persaud										NY 11419			
	20a. METHOD OF DISPOSITION			20b. PLAC	CE AND DATE	OF DISPOSITION (DAT						٦
	1 Burief 2 Cremetion 3 4 Donation 8 Offier (Specify		from State	cemetery,	crematory or o	nd Crem	ation	10-	28 Wes	t Ra	hvlo	n NY		
	21. SIONATURE OF FUNERAL SERV	ICE LICENS	SEE	/	3 2020	22. NAME	AND ADDRESS OF	FACILITY			0,10	11, 111		\exists
	1 A	1/	011	3.4	00007		Funeral							
-	23 PART I. Enter the disease	Or com	plications that o		00827	933 6	ist Ave	Silv	er Spi	ing,	MD		_	ᅵ
	anock, or heart te	llure. Liat	only one ceuse	on each li	ine.	or enter tha in	ode or dying, a	uch ma care	liac or reapi	ratory an	reat,	Approxi	Betwee	
									Onset a	nd Dear	th			
	resulting in death)	a	KEN IN	TUR		-VICB								
_														
S	Sequentially list conditions,	b	DUE TO (OI	AS A CONS	SEQUENCE OF	FI.								4
¥	Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING DUE TO (OR AS A CONSEQUENCE OF): DATE TO A STATE OF THE CAUSE O													
F	CAUSE (Disease or injury that initiated events	CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF):									-			
분	resulting in death) LAST	d.												Н
2	DART II Other classificant and	-ttate												
EDICAL CERTIFICATION	PART II. Other algorificant conditions contributing to death but not resulting in the					In the underlying	ng causa given	In Part I.	24a. WAS AN PERFOR		24b	WERE AUTOPSY AMAILABLE PRICE		
ă	(HRD)() PULMONITICY ATTREST ATT HOME (CHRONIC)							OF DEATH?	CAUSE					
ž	OBSTRUCTIVE FULMONARY DISCASS								1 - YES 2 X	NO	-1			
Z	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES AND UNCERTAIN													
2	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: OTHER:													
PHYSICIAN:	1 TYES 2 NO	1 (Inpatient 2 E		3 🗆 DOA		me 8 🗆 Residenc	e 8 🗆 Other	(Specify)					
	27. MANNER OF DEATH 10 Natural 8 □ Pending		28e. DATE OF IN. (Month, Day,	IURY Year)	28b, TIM INJ		JURY AT ORK?	28d. DEŞ	CRIBE HOW IP	URY OC	CURED			٦
B≼	2 Accident Investig						YES 2 NO							_
_	3 Suicide 8 Could not be 28s. PLACE OF INJURY — At home, farm, a building, etc. (Specify)				street, factory, off	treet, factory, office		281. LOCATION (Street and Number or Rural Route Number, City or Town, State)					7	
COMPLETED	4 Homicide datermined													
릴	29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.										٦			
Š I	one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
BE C	290 LICENSE NUMBER 29d. DATE SIGNEO (Month, Day, Year)									\dashv				
	Sterry (i Kery - MD					D36252 >00CTS					25,199	15		
٤	30. NAME AND ADDRESS OF PERSO	N WHO CO	OMPLETED CAUSE	OF OEATH (I	_		11 11		1.1.5.			1.7		4
	STEVEN TI KHRIYA, U.D. 11501 GEORGIA NE#515, WHOTON UD 20902													
	31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE													
- 48	OCT 2 7 1995	July	Studier	nardall										- [

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TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a few months and the second of the standing physician and concerns the few months are second of the second of

IMPORTANT. If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once,

DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

	REGISTRAR		CERTIF	ICATE OF	DEATH	REG.	NO.				
	1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH								3. TIME OF DEATH		
	JUNIUS	PRIC	E			Oct.	24 :	1995	9:20 P. M		
NR.	4. SOCIAL SECURITY NUMBER 5. SEX	6. AGE	(In yrs. lest birthday) 73 YRS.	F UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Yea March 12	l ir)	8. BIRTH Countr	IPLACE (State or Foreign		
	9a. FACILITY NAME (If not institution, give street and n Holy Cross Hospital		96. CITY, TOWN OR LOCATION OF DEATH Silver Spring				,1922 Louisa, VA. Sc. COUNTY OF DEATH Montgomery				
5	RESIDENCE OF DECEDENT										
BY FUNERAL DIRECTOR	10e. STATE 10b. COUNTY		Washington, D.C.					10d. INSIDE CITY LIMITS? 1 X YES 2 NO			
	100. STREET AND NUMBER 800 Jefferson St., 1	101, ZIP CODE 2001						nited States			
	1 Never Married 2 X Married FOR	DECEDENT EVER I CES? 1 VES ES, GIVE WAR OR D	YES 2 NO If yes, specify C			NT OF HISPANIC ORIGIN? (Specify Yea or No-			14. RACE — American Indian, Black, White, etc. Specify:		
	1s. DECEDENT'S EDUCATION (Specify only highest grade completed)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working			16b. KIND OF BUSINESS/INDUS			Black Black		
COMPLETED		(1-4 or 5+)	Iffe. Do NOT use retired.)					Care Center			
S	17. FATHER'S NAME (First, Middle, Last)		16. MOTHER'S NAME (First, Middle, Mak								
B	Pierce N. Pr:	ice					e Cash				
10	Samuel Broadnax		2108 T	Willow T	ree Lane	Route Number, City or , Temple	Town, State, Z Hills	, MD.	20748		
	20s. METHOD OF DISPOSITION 1 X Burisi 2 Cremation 3 Removal from 4 Donation 5 Other (Specify)	D. PLACE AND DATE	28/95 20c	20c. LOCATION — City or Town, Stata Brentwood, MD.							
	1 X Burlet 2 Cremetton 3 Removed from State 4 Donation 5 Other (Specify) Ft. Lincoln Cemetery 10/28/95 Brentwood, MD. 22. NAME AND ADDRESS OF FACILITY McGuire Funeral Service, Inc.										
	7400 Georgia Ave., N.W., Washington, D.C.										
1	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one ceuse on each line. Approximately a cardiac or respiratory arrest, intermediately and a cardiac or respiratory arrest, intermediately and a cardiac or respiratory arrest, intermediately arrest, and a cardiac or respiratory arrest, intermediately arrest, and a cardiac or respiratory arrest, and a cardiac or r								Approximats interval Between Onset and Daath		
٦	resulting in death)	DUE TO (OF AS A CONSEQUENCE OF):							3 days		
NO	Sequentially list conditions, b.	1 cute	Reno	1 fa	ilure				3 days		
CATI	if arry, leading to immediate cause. Enter UNDERLYING										
CERTIFICATION	CAUSE (Disease or injury that initiated events resulting in death) LAST C. DUE TO (OR AS A CONSEQUENCE OF):										
	PART II. Other significant conditions contrib	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY PINDINGS									
EDICAL	PART II. Other significant conditions contributing to death but not resulting in the underlying couse given in Part I. 24s. Was an AUTOPSY PERFORMED? 1 — YES 2 X NO							240.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
N: ME	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES □ NO 🔼 UNCERTAIN □										
N S	25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)										
l Si	HOSP	ITAL: itlent 2 - ER/Out	patient 3 🗆 DOA	OTHER: 4 Nursing Hon	e 5 🗆 Rasidenca	6 Other (Specify)					
Y PHYSICIAN:	Natural 5 Pending	DATE OF INJURY (Month, Day, Year)	28b. TIM INJ		PRK?	28d. DESCRIBE HOW INJURY OCCURED					
red BY	- Petroenic	PLACE OF INJURY building, etc. (Spec	JURY — At home, farm, street, factory, office (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
٦	29a. CERTIFIER CERTIFYING PHYSICIAN: To 1										
COMPLETED	(Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated.										
B	296, SIGNATURE AND TITLE OF CERTIFIER D38262 29d. DATE SIGNED (Month, Day, Year) D38262 DCC 1984 25 1995										
2	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print) ANUKITA MENDALIRATTA 2401 Research BLUD for kuille and 20850										
	31. DATE FILED (Month, Day, Year) 32.	REGISTRAR'S SIGN	ATURE	Keneo	YCH TSU	U) Hock	will	M	05830		
	OCT 27 1995 Julied	Tavolson Ra	rdall								

DHMH-16 Rev 1/89

FOR STATE REGISTRAR

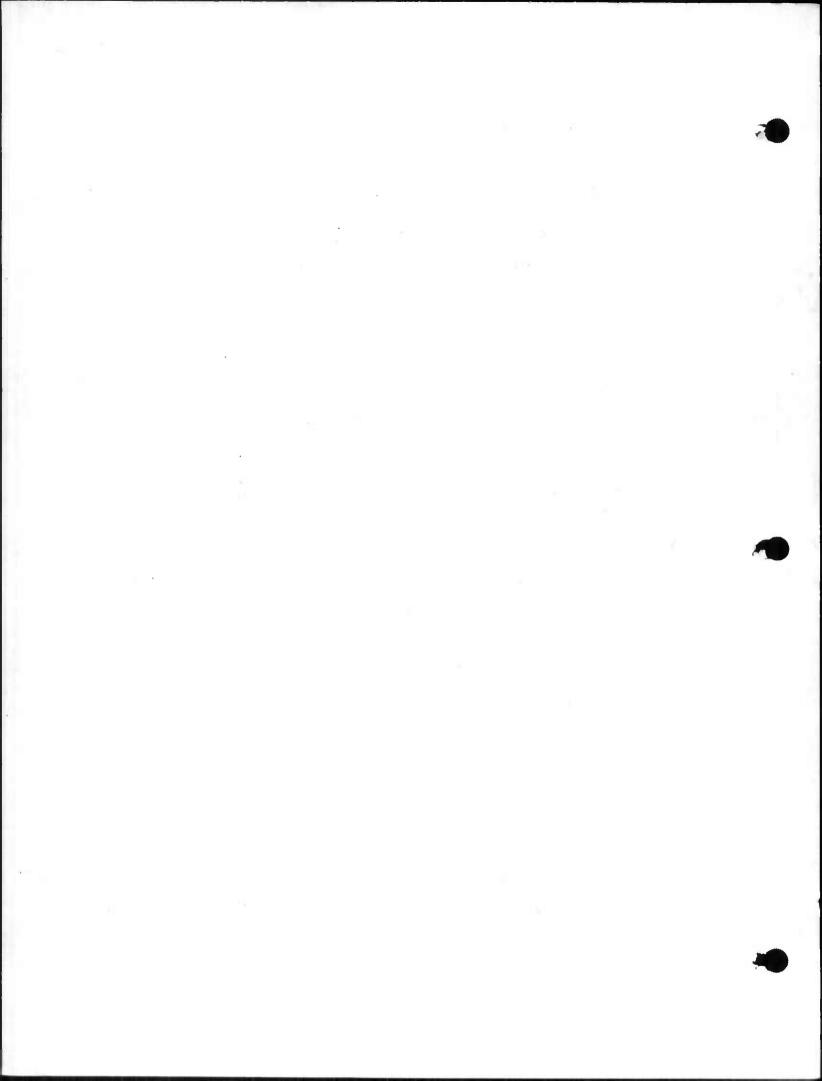
31. DATE FILED (Month, Day, Year)
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22. REGISTRAD'S SIGNATURE

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TAL OR ATTENDING PHYSICIAN: TH	341 DIDECTED After this cardifficate has been sid
OR	DIDE
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	1. DECEDENT'S NAME (First		DATI	207.0000						MONT	OF DEATH		YEAR	3. TIME OF DEATH
- 1	STELLA	C.		EOLOGOS		,		,		-	ber 21	, 19	95	12:00 P M
	4. SOCIAL SECURITY NUMBER 234-38-9384		5. SEX	6. AGE (In yrs.		IF UNDI	DAYS	HOURS	24 HRS.	(Monti	OF BIRTH	211	Count	
	9e. FACILITY NAME (If not in				T THS.	95 CIT	TV TOWN	OR LOCATI	ON OF D		6, 19	_	INTY OF D	ece
Œ	Montgomery			1			ney	ON LOCALI	UN OF DE	CAIN				omery
2	RESIDENCE OF DEC	CEDENT	i nospi	-aı		01	пеу					PIC	niego	mery
DIRECTOR	10e. STATE	10b. COUNTY					OR LOCA			,				10d. INSIDE CITY LIMITS?
	Maryland		gomery		B:	rook	evil							1 TYES 2 X NO
FUNERAL	10e. STREET AND NUMBER		Dood				10	01. ZIP COD				10g. CIT		WHAT COUNTRY?
NE I	309 Havilar	id Mill	12. WAS DECEDE	NT EVER IN II S	ARMEO	12	WAS DE	208		NIC OBIGIN	17 (Specify Yea	or Mo	USA	E — American Indian,
84	1 Never Married 2 3 Widowed 4 Dive		FORCES?	YES 2			If yes, s	pecify Cube S 2 X NO	m, Mexica	n, Puerto		01110-	Spec	k, White, etc.
ED		EDENT'S EDU		16e.	DECEDENT'S	USUAL work don	OCCUPAT	ION lost of worki	na	16b	. KIND OF BUS	SINESS/IN	DUSTRY	
	Elementary/Secondary (College (1-4 or 5		Illa. Do NOT u	ise retired.	(.)				D - = + -			
COMPLET	6	Aladati di uni	0		Self-	empı	oyed	_			Restau			
	17. FATHER'S NAME (First, A Ignatius Pi		2							ME (First, i	Middle, Malden	Surname)		
8	19e. INFORMANT'S NAME (,		19b. MAILIN	G ADORE	SS (Street				ber, City or Tow	n State 7	in Codel	
9	Maria Manol													yland 20833
	20e, METHOD OF DISPOSIT	TION		20b. PLA	CE AND DATE	OF DISPO	OSITION (A	Vame of		DAT				
	1 N Burlel 2 Crematic	(Specify)	- 1	Gate	of H	eave	n Ce	emete	ry	10/	24511	er S	Sprin	ng, Maryland
	21. BIGHATURE OF VINERO	A SERVICE LIC	TENSOR!	2									ii Fu	neral Home
	► Nucl	60	Grand								re Ave		1904	
	23. PART I. Enter the	iseases, or	complications th	at caused the	deeth. Do									Approximata
	shock, of h IMMEDIATE CAUSE (Fi		List only one ca			,								Onset and Death
	disease or condition	→	. A+	rial	F	br	.//	at	02	J				7
			DUE TO	O (DR AS A CON	SEQUENCE (OF):					-		1	1.1
NO	Sequentially list condit	tions.	o. Ver	rkbro	ul	60	m	pre	122	01	F	aa	tore	lwk ?
CERTIFICATION	if sny, lasding to imme	diata	M	tral	SEDUENCE	Din	0 (1 6						2
FIC	CAUSE (Disesse or injute that initiated events		C. OUE TO	D (DR AS A CON	ISEDUENCE (OF):	د ن	1)						-
FI	resulting in death) LAS	ST .	Pn	eomo	onice									10
	PART II. Other significa		u/											
MEDICAL	Construction of the constr		Doro J		or resulting	in the	unoariyii	ng cause	given in	rart i.	24s. WAS AN PERFOR		248	AWAILABLE PRIOR TO COMPLETION OF CAUSE
EDI	5.		agrar	-	no.	111	į.				1 TYES 2	THO		DF DEATH?
	DID TOBACCO U				EATH V	ון אַ	NO [T LIN	CEDTAL	N D	,			1 TES 2
PHYSICIAN	25. WAS CASE REFERRED		KIBOTE TO C		LACE OF DE				LKIAI					
SIC	EXAMINER?		HOSPITAL:	☐ ER/Outpation	t 3 🗆 DOA	OTH		me 5 🗆 R	esidence	6 C Other	er (Specify)			
H	27. MANNER OF DEATH		28e, DATE O		28b. TI	ME OF	28c. IN	JURY AT		_	SCRIBE HOW I	NJURY O	CCURED	
ВУ Р	1 Matural 5 🗆	Pending Investigation	(MOINI),	Day, rear)	- "	IJURY M		YORK?	ND					
	3 Suicide 8	Could not be	28e. PLACE building	DF INJURY — A	t home, farm,	street, fr	actory, off	lice			CATION (Street or Town, State)		er or Rural	Route Number,
TE	4 Homicide	determined								,				
PL		TIFYING PHYS	ICIAN: To the best of	of my knowledge	, death occur	red at the	e time, de	ite end plec	e, end due	to the ce	use(e) end me	nner se ati	eted.	
COMPLET	one) 2 MED	DICAL EXAMINI	ER: On the basis of	exemination and	l/or investigat	lon, In m	y opinion,	death occu	red at the	time, date	e end place, er	nd due to t	the cause(e) end menner ee stated.
BE C	29b, SIGNATURE AND TITL	E OF CERTIFIE	R						ENSE NU		~ ,			D (Month, Day, Year)
TO B	apr	occ	m					1 1	P	145	5956	-6	lct	2/ 1995
	30. NAME AND ADDRESS OF	R P A	DED ICH	USE OF DEATH	(ITEM 27) (30)	e, Print)	Ce	ОЦІІ	10	100	111	(EV	LI	20852
	DIND	PLU	DERICK	- 101	1171	UN	UC 1	17/4	11 -	PL	ULL	JUY.	MIT	,

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.



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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be not start the State Dent, or Health and Mental Hindere prior to burial, cremation, or removal.	IMPORTANT: If Nem 28 is marked, or Item 23 shows any Injury, or other traumatte event, the medical examiner must be notified at once.
TO THE HOSPITAL OR ATTENDIN	TO THE FUNERAL DIRECTOR: After this c	IMPORTANT: If item 28 is n

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1 - FOR STATE REGISTRAR

1. DECEDENT	S NAME (First, Midd	, , ,	m Irving	Pow	ers				2. DATE O MONTH Octob	per 23		YEAR	3. TIME OF DEATH 1:58 I	Р м
	-1875A	5. SEX	6. AGE (In yrs. les	t birthday)	IF UNDER	1 YEAR DAYS	IF UNDER	24 HRS. MIN.	7. DATE OF	20, 1	905	Count		gn
		on, give street and number)			Oh CITY	TOWAL (OR LOCATI	ON OF D		20, 1		NTY OF E	rginia	
	ranklin	Street			- 12	100	singt		EATH		9.000		jomery	
4405 H RESIDENC 100. STATE Maryla	E OF DECEDI	COUNTY		40. 017	TOWARD A	201004	ZIONI						10d, INSIDE CITY	
IN. STATE				10C, CI1	Y, TOWN								LIMITS?	
		Montgomery					singt				EVALUATE N		1 TYES 2 XXNO	0
		a .				10							WHAT COUNTRY?	
4405 1	ranklin						2089	_				_	States	
	erried 2 X Merri	FOROSCO 4	TEVER IN U.S. AF YES 2 1 WAR OR DATES			II yes, sp		ın, Mexici	NIC ORIGIN? an, Puerto Rid fly:		or No	14. RAG Blec Spec	E — American Indian, ik, White, etc. :ity: White	
	15. DECEDEN	IT'S EDUCATION	16a, DE	CEDENT'S	USUAL O	CCUPATION	ON	-	16b.)	UND OF BUS	INESS/IN	DUSTRY	WILLEC	
		est grade completed)	(6		work done		ost of worldi	ng						
Elementary	/Secondary (0-12)	College (1-4 or 5	*)	Mana	ger				- 4	Groce	ry S	tore	S	
17, FATHER'S I	AME (First, Middle,	Last)					18. MOT	HER'S NA	AME (First, Mi	ddle Maiden	Sumame)			
		William						Arne	ette E	lam_				
198, INFORMA	NT'S NAME (Type/P								Route Numbe				1 0000	_
	na B. Po	wers	1				-	eet,	Kensi			_		<u> </u>
1 X Burlel 2	OF DISPOSITION Cremetion 3 Other (Special	Removal from State	cemetery cre Goshe					28,	1995				own, State , Marylar	nd
21.60GMATUR	M. L.	Not scenses	mo MC	0846	Ro	ber't	Chas	Půmi e,	phrey inc.	Funer 7557 2081	al H	lome/	Bethesda n Avenue	-
if any, lead cause. Ente CAUSE (Dis that initiate	y ilst conditions, ng to immediate r UNDERLYING	b DUE TO	Q S P T O OR AS A CONSE O OR AS A CONSE O (OR AS A CONSE	OUENCE O	DF):	<u> </u>	1101	Q e					Acute a Chronic Years	2
PART II. Ot		onditions contributing to			in the u	nderlyln	g cause	given ir		24a, WAS AN PERFOR	RMED?	24	b. WERE AUTOPSY FINE AVAILABLE PRIOR TO COMPLETION OF CAI DF DEATH? 1 YES 2 (X) NO	USE
	BACCO USE	CONTRIBUTE TO CA		TH Y				CERTAI	IN 🔯					
EXAMINE	37	HOSPITAL:			OTHE	R:								
1 TYES		28e. DATE O	ER/Outpatient	28b. TIN	-		JURY AT	asidence	6 Other	(Specify)	N IUDY O	CHRED		
1XX Natur 2 Accid	al 5 Pend	(Month, i	Day, Year)		JURY	W	ORK? YES 2 [□ NO	200. DESC	AIBE HOW I	NJUHY OC	CURED		
3 Sulci	de 8 Coul	d not be mined 25s. PLACE building	OF INJURY — At h., atc. (Specify)	ome, farm,	street, fed	tory, offic	ca			TION (Street in Town, State)		er or Rural	Route Number,	
29a. CERTIFIE (Check on one)	Y TEA GEHTIFYII	NO PHYSICIAN: To the best of EXAMINER: On the best of											(a) and manner as ata	ted.
-		<u> </u>												
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		nson who completed car D., 809 Veir				kvi1	le,	Mary	land	2085	1			
31. DATE FILE	OCT 25		AR'S SIGNATURE	rde II										
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	1 - FOR STATE REGISTRAR		STATE OF N	ARYLAND /		RTMENT					HYGIEN	_		
	1. DECEDENT'S NAME (Firs	t, Middle, Last)	-			TOTAL		DEA		2. DATE OF	_			3. TIME OF DEATH
	ARTHUR	PELTEY	CIRKS							MONTH		YAY	YEAR 1995	5:05 A M
	4. SOCIAL SECURITY NUM		5. SEX	8. AGE (In yrs. les	t birthday)	IF UNDER	1 YEAR	IF UNDER	24 HRS.	7. DATE OF	BIRTH	2		IPLACE (State or Foreign
	579-42-3506		1∑ M 2 □ F	64	YRS.	MONTHS	DAYS	HOURS	Min.	(Month, D	ay, Ybar)	021	Count	(Y)
	9a. FACILITY NAME (If not in	nstitution, give si	treet and number)	04	-	9b. CITY	TOWN C	R LOCATIO	ON OF DE	July 2	./,		NTY OF D	ance
E I	Howard Coun	ty Hoe	nital			1.0			011 01 01	-8111				
ह	RESIDENCE OF DE	CEDENT	pitai				olum	Dla				<u> </u>	owar	d
DIRECTOR	10e. STATE	10b. COUNTY	,		10c. CIT	Y, TOWN	OR LOCAT	TON						10d. INSIDE CITY LIMITS?
					Wa	shin	gton	, D	. C.					1XXYES 2 NO
M	10e. STREET AND NUMBER						10f	ZIP CODE	E .			10g. CIT	IZEN OF V	WHAT COUNTRY?
빌	3710 Livi	ngston	Street	N. W.					2	0015			U. S	. A.
FUNERAL	11. MARITAL STATUS		12. WAS DECEDEN	T EVER IN U.S. AR	MED	13.	WAS DEC	ENDENT O	F HISPAN	IC ORIGIN? (S	pecify Ye			E — American Indian, k, White, etc.
BY	1 Never Married 2 3 Nichard 2 Dividence 2 Dividence 2 Dividence 3		IF YES, GIVE W	AR OR DATES			1 TYES	2 X NO	Specify	n, Puerto Rica /:	n, etc.)		Speci	
			Korea											
ш	(Specify on	EDENT'S EDUC y highest grade	completed)	16a. DE:	ve kind of	USUAL OF work done	during mo	ON st of workin	g	16b. KII	NO OF BU	SINESS/INI	DUSTRY	
2	Elementary/Secondary (3-12)	College (1-4 or 5 a	•)	inet		stal				.1 *			
COMPLETED	17. FATHER'S NAME (First, M	fiddle, Last)		Joan	THE	. 1.11	Stal		ICD'C NA	ME (First, Midd	abine			
	Aram F	elteki	an							upolj:		Sumame)		
8E	19a. INFORMANT'S NAME (Type/Print)		191	MAILING	ADDRESS	R (Street a			Route Number,		on Chain 76	o Codel	
2	Pierre P	elteki	an	4						ay Ke				20895
	20a. METHOD OF DISPOSIT		nval from State	20b. PLACE	ND DATE	OF DISPOS	ITION (Na					CATION -		
	4 Donation 5 Donate	(Specify)		- Park1	awn	Ceme	terv			10/25	Ro	ckvi	11e,	MD
9.1	21. SIGNATURE OF FUNERA	L SERVICE LIC	ENSEE			22.	NAME AN	D ADDRES	S OF FA	Jos	eph	Gaw1	er's	Sons
0	1/1	ze	·Wa	-				I Av			-	ton,		C. 20016
1	23. PART I. Enter the d	is∳alsea, <u>Dr.C</u> aakt fellure. i	omplications that Liet only one cau	t ceused the da-	eth. Do r	not enter	the mo	da of dyi	ng, sucl	h as cardiac	or reep	ratory an	rest,	Approximata Interval Batween
	IMMEDIATE CAUSE (Fig	nel	_											Onset and Death
- 1	disease or condition resulting in death)	→ ,	CONGE				LUNE							1 YEAR
				(OR AS A CONSEC										
No.	Sequentielly list condit	ions,	12CHEN	CARDIO	14706t	אאנונ								(h) Khoch
F	If any, leading to imme cause. Enter UNDERLY						0 0	I. Nor	_					
윤	CAUSE (Disease or Injuthat initiated events		APTERIOD DUE TO	OR AS A CONSEC			AKT O	n end f						CHKHOWN
CERTIFICATION	resulting in daeth) LAS	T	HYPERTE	Carlon										UNKNOWN
S														O P KHOCOP
A.	PART II. Other algorifice	ont conditions	contributing to	death but not n	eauiting I	in the un	derlylng	cause g	iven in	Part I. 24	. WAS AN	AUTOPSY	24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
8										1	YES 2	NO		COMPLETION OF CAUSE OF DEATH?
¥.														1 TES 2 NO
PHYSICIAN: MEDICAL	DID TOBACCO U		RIBUTE TO CA					UNC	ERTAIN	1 🗆				
5	25. WAS CASE REFERRED T EXAMINER?	O MEDICAL	HOSPITAL:			OTHER								
YS	1 NES 2 NO		HOSPITAL:			4 🗆 Nuri	sing Home	_	aldence	6 Other (Sp	ecify)			
		Pending	26a. DATE OF (Month, De	INJURY sy, Year)	28b. TIM	E OF URY	26c, INJU WOI	RK?		28d, DESCRI	BE HOW I	NJURY OC	CURED	
BY	L _ radioent	Investigation	28a PLACE OF	F INJURY — At hor	no dono			ES 2	NO	- Construction				
		Could not be determined	building,	atc. (Specify)	TIO, TECTIS, 1	Rreet, facto	ory, office)		26f. LOCATIO City or To	N (Street i wn, State)	and Number	or Rural R	loute Number,
	29a. CERTIFIER	TENNIS TO THE				*						-		
COMPLET	(Check only		CIAN: To the best of											
8			On the pasts of the	and and and a		ri, in my o	pinion, de				placa, an) and manner as stated,
8	296 SIGNATURE AND TITLE		Jien M.	0				29c. LICE						(Month, Day, Year)
0	(ω.	111000	F).1	v.				Ud	723	37			JT 2	3,1995

Mowaters M.D 30, NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

MEDICAL 11085 LITTLE POTLYENT PKWY, COLUMBIA DPIZ BLOY 32. REGISTRAR'S SIGNATURE

31. DATE FILED (Month, Day, Year) 26 1995 Devilson Royall

MCWATERS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within—5 hours after death. Page 6 may be retained by the hospital or attending physician.

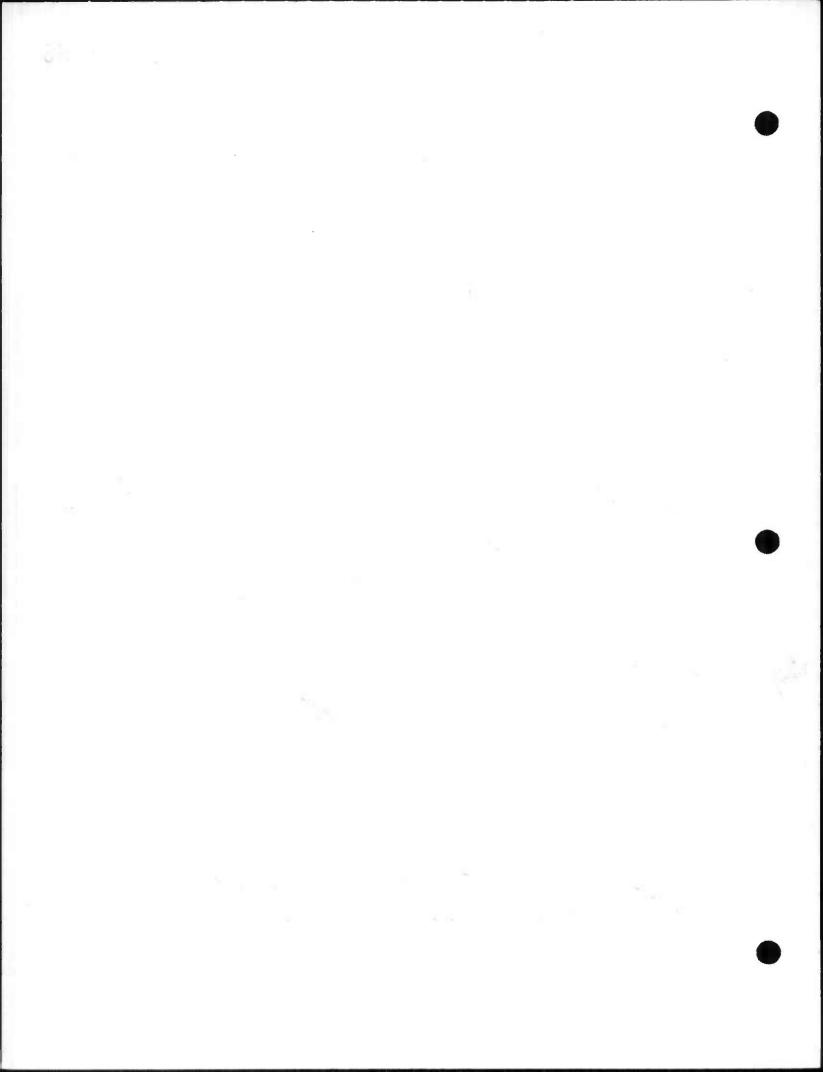
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

_	REGISTRAR			EKIIF	ICATI	e Or	DEAL	I H	F	REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)	ERNARD	POVIC	Н					2. DATE OF MONTH	DEATH	W.	YEAR	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER	5. SEX							-	_ <u>-</u> _	995		2:55 A N
	578-54-1113	1XXM 2 □ F	6. AGE (In yrs. 85		IF UNDER	DAYS	HOURS	MIN.	7. DATE OF S (Month, De JUNE 8	ly, Year)	10	0. BIRTH Count MAI	
-	90. FACILITY NAME (If not institution, give s CARRIAGE H	street and number) ILL BETHE	SDA		9b. CITY	, TOWN	BETH		EATH		9c. COL	INTY OF D	
3	RESIDENCE OF DECEDENT						DEIL	TE SUF	4		110	711100	TIERI
DINEGION	10a. STATE 10b. COUNT	Υ			Y, TOWN								10d. INSIDE CITY LIMITS? XX YES 2 NO
	10e. STREET AND NUMBER			1 112	OHILI		I. ZIP CODE				10- 017		VHAT COUNTRY?
	2800 QUEBEC STREE						20008						STATES
	11. MARITAL STATUS 1 Never Married 2 Ameried 3 Widowed 4 Divorced	12. WAS DECEDEN FORCES? 1] IF YES, GIVE W	XYES 2			If yes, sp	CENDENT O lecify Cuber 2 X NO	n, Mexica	NIC ORIGIN? (S in, Puerto Rica y:	pecify Yes n, etc.)	or No-	Black	— American Indian, k, White, etc.
	15. DECEDENT'S EDU (Specify only highest grade	completed)		DECEDENT'S (Give kind of ife. Do NOT us	work done	CCUPATION MO	DN ost of workin	g	16b, KIN	ID OF BUS	INESS/IN		
	Elementary/Secondary (0-12)	College (1-4 or 5+)		TORN	EY				LEGA	L/LA	W	
	17. FATHER'S NAME (First, Middle, Last)						18. MOTH	IER'S NA	ME (First, Midd	le, Maiden	Sumeme)		
	NATHAN POVICH						ROS	A OR	LOVICE	I			
	19a, INFORMANT'S NAME (Type/Print)			19b. MAILING	ADDRES	S (Street e	nd Number	or Rural I	Route Number, (City or Town	, State, Zi	p Code)	
	FAY POVICH			2800-	QUEB	EC S	ST. N	W, W	ASHING	TON-	DC 2	0008	
	20a. METHOD OF DISPOSITION XXSuriel 2 Cremation 3 Ram 4 Donation 5 Other (Specify)	oval from State		E AND DATE	OF DISPOS	SITION (NE			10-24	20c. LO	CATION -	City or To	
ĺ	21. SIGNATURE OF PONERAL SERVICE LIC	CENSEE	-		22. D	NAME A	ND ADDRES	SS OF FA	CILITY				PELS, INC.
	Potent	1	me	-									MD 20852
	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	b. DUE TO	ary a		BCL	no	tie	4	red	ion	100	oon	14
	resulting in death) LAST	d											
	PART II. Other aignificent condition	na contributing to	death but not	resulting	In the un	derlyin	g ceuse g	lven in		PERFOR	MED?	24b.	WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
ı							1		_				1 YES 2 NO
	DID TOBACCO USE CONT	RIBUTE TO CAI				NO B	UNC	ERTAIN	1 🗆				
	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PL	ACE OF DEAT	_								
	1 TES 2 NO	1 Inpatient 2 I	ER/Outpatient	3 DOA	OTHER 4 V. Nun		e 5 🗆 Res	sidence	8 Other (Sp	ecify)			
	27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	28e. DATE OF (Month, Da	INJURY ly, Ybar)	28b. TIM INJ	E OF URY M	28c. INJ WO 1 1	RK7	NO	28d. DEŞCRII	BE HOW IN	JURY OC	CURED	
	3 Suicide 8 Could not be determined	28e. PLACE Of building, o	INJURY — At I	noma, larm, s	Hreet, fact	ory, offic	•		201. LOCATIO City or To	N (Street a wn, Stete)	nd Numbe	r or Rural R	outs Number,
	29s. CERTIFIER (Check only one) 1 X CERTIFYING PHYSI (Check only one) 2 MEDICAL EXAMINE												and manner ee stated.
	296. SIGNATURE AND TITLE OF CERTIFIES	1 /	7	,			29c. LICE	NSE NUM	IBER	Т	29d, DAT	E SIGNEO	(Month, Day, Year)
	(has	///	osto	>n	12		DA	4	170				ER 23, 1995
	30. NAME ADDRESS OF PERSON WA	COMPLETED CAUS	E OF DEATH (IT	ЕМ 27) (Туре,	Print) 5	530	Wis	con	SIN A	ue,			
	31. DATE EILED (Month, Day, Year)	32. REGISTRAI	OS 7	CR		1 .	<u>, </u>		heuy	Ch	use	, MI	020815
	VVI 26 1995	John Davel	war Ranka	11.									

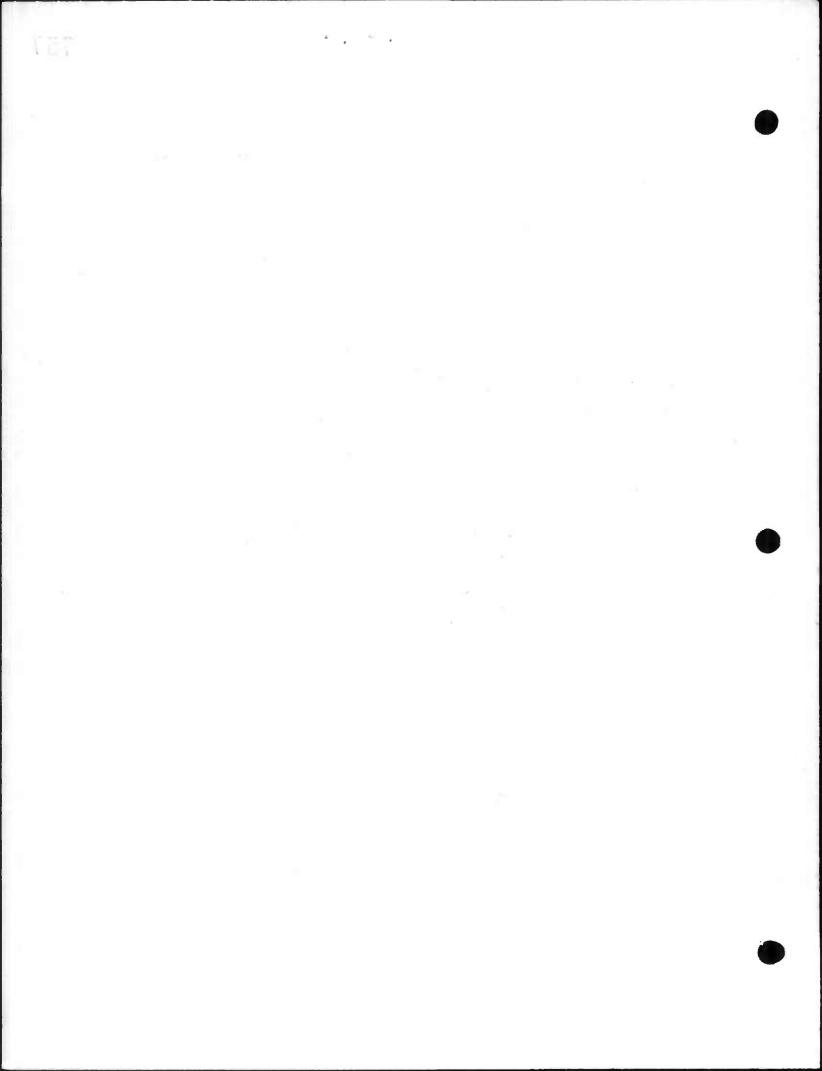


the hospital or attending physician. Befached for use as the burial-transit permit. Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

-	FOR STATE REGISTRAR	STATE OF MARYLAND / DEPARTMENT OF H CERTIFICATE OF	
, D	DECEDENT'S NAME (First, Middle, Last)	at Milaler	2. DATE OF OEATH

	1 - STATE REGISTRAR		TMENT OF ICATE OF			ENTAL HYGIENI REG. NO.		
	1. DECEDENT'S NAME (First, Middle, Last) Joshua albert Quick	ley 5	5r			2. DATE OF DEATH	95	3. TIME OF DEATH
2	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. 212-14-3414 1X) M 2 - F 33	last birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 2	HRS. 7	DATE OF BIRTH	8. Bit	RTHPLACE (State or Foreign punity) M D
OR	Ba. FACILITY NAME (If not institution, give street and number) HARFOR I MEM HOS NITA		96. CITY, TOWN	1 /2	OF DEAT		Sc. COUNTY O	of DEATH
DIRECTOR	10a. STATE 10b. COUNTY HARFOOD	11	r town or Local	ITION				10d. INSIDE CITY LIMITS?
	100. STREET AND NUMBER SCHESNOEALE	1100		21001	,		10g. CITIZEN O	OF WHAT COUNTRY?
BY FUNERA	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES	NO	If yes, a		Mexican,	ORIGIN? (Specify Yes Puerto Rican, atc.)	В	ACE — American Indian, Black, White, atc.
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	(Give kind of w life. Do NOT yes	USUAL OCCUPAT work done during in e retired.)	ON ost of working		16b, KINO OF BUS	NESS/INDUSTR	p)//+C/
BE COM	T. FATHER'S NAME (First, Middle, yest) SAMES HI QUICKLEY She	30,700	3.44	16. MOTHE	R'S NAME	(First, Migdle, Malden S	(urgeme)	
TO B	MARY STANS DUTY	19b. MAILING	ADDRESS (Street	and Number of	Rural Rou	Abert	Stare, Zip Code)	mp
		atory of off	W HIM	5		10-25	ATION — City or	r Town, State
	· July Pro May		Hou	re w	o de	oul some	P	
	23. PART I. Enter the diseases, or complications that caused the shock, or heart failure. List only one cause on each I iMMEDIATE CAUSE (Final disease or condition resulting in death)	Ine.	57	Tre	g, such a	to cardiac of respir	etory arreat,	Approximate interval Between Onset and Death
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	BEQUENCE OF	k	B. I				
MEDICAL	PART II Other aignificant conditions contributing to death but no	t resulting in	n the underlyin	g ceuse giv	en in Pa	24a, WAS AN A PERFORM 1 YES 2	NED?	24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
PHYSICIAN:	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DI 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PI	ACE OF DEATH	NO CHECK ONLY ONE		RTAIN	Ø		
	1 YES 2 NO 1 Inpatient 2 ER/Outpetient 27. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year)		4 Nursing Hor OF 28c. IN JRY	JURY AT ORK?	21	Other (Specify) Bd. DESCRIBE HOW IN.	JURY OCCURED	
TED BY	2 Accident Investigation 3 Suicide 6 Could not be detarmined 28a. PLACE OF INJURY — At building, atc. (Specify)	home, farm, at				Bf. LOCATION (Street an City or Town, State)	d Number or Run	rel Route Number,
COMPLET	29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/							se(a) and manner as stated.
TO BE	296. SIGNATURE AND TITLE OF CERTIFIER WHAT MA			29c LICEN	SE NUMBE	V	29d, DATE SIGN	NED (Month, Day, Year)
	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (I	TEM 27) (Type, I	Print) GMY	B	m	7 7/0	78	
	UCI 23 1995 Jalia Manuari	ardall						



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

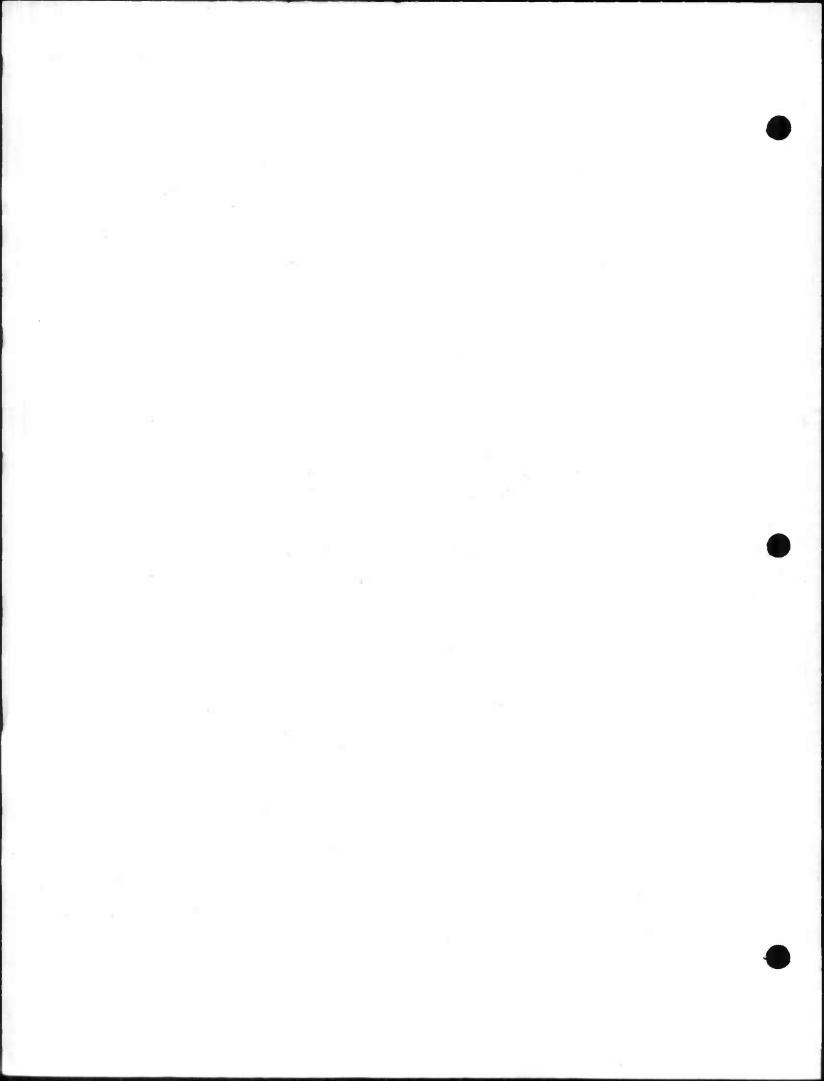
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial. cremation, or removal.

IMPORTANT: If item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CLI	20 11 14	CATE	J. DEA		R	EG. NO.			
- 1	1. DECEDENT'S NAME (First, Middle, Last)							2. DATE OF	DEATH			3. TIME OF DEATH
	Frances Naomi Ric							Octobe	er 24	. 19	YEAR	10.00 AM
	4. SOCIAL SECURITY NUMBER	· ·	AGE (In yrs. lest b	(etheles)	IF UNDER 1 YE	to le more	R 24 HRS.	7. DATE OF E		, 19		10:00 A M
						YS HOURS	MIN.	(Month, Da	y, Year)		Counti	γ)
	217-94-2631	1 🗌 M 2 💢 F	81	YRS.				Jan. 1	4, 19	914	Ma	ryland
	9e. FACILITY NAME (If not institution, give st	treet end number)		1	96. CITY, TO	WN OR LOCAT	ION OF DE	ATH		9c. COU	NTY OF D	EATH
FUNERAL DIRECTOR	Citizens Nursing	Home			Frede	rick				Fre	deri	ck
ĔΙ	RESIDENCE OF DECEDENT									110	deri	CK
ŭ	10e. STATE 10b. COUNTY	1		10c. CITY,	TOWN OR L	OCATION						10d. INSIDE CITY
	Maryland Fr	ederick		Libe	rtyto	านาก						LIMITS?
5	10e. STREET AND NUMBER			ZIDC	1 0 00	101, ZIP COD	NE .		1	10- C/T	TEN OF Y	WHAT COUNTRY?
AA						47-17-17						THAT COUNTRY?
9	11927 Main St.					2176	2			U.	S.A.	
5	11. MARITAL STATUS	12. WAS DECEDENT E	VER IN U.S. ARME	D				IIC ORIGIN? (S		r No—	14. RACI	E — American Indian, k, While, etc.
	1 X Never Merried 2 Merried	FORCES? 1	OR DATES			YES 2 X NO		n, Puerto Rica:	n, etc.)		Spec	
à	3 Widowed 4 Divorced			1								"Black
COMPLETED	15, DECEDENT'S EDUC		16e. DECE	DENT'S U	SUAL OCCU	PATION		16b. KIN	D OF BUSI	NESS/INC	DUSTRY	
	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give	kind of wo	rk done durir retired.)	ng most of work	ing					
7	7	College (14 of 5 f)		Home	maker				Home			
≥	17. FATHER'S NAME (First, Middle, Lest)					40, 1407	THE MIN ALA	ME (First, Midd				
BE	William H. Rice	e, Jr.				_		zetta				
2	19e. INFORMANT'S NAME (Type/Print)		19b.	MAILING A	DDRESS (St	reet end Numbe	or Aural I	Route Number, (City or Town,	State, Zip	Code)	
F	Sterling R. Rice		11	927	Main	St. Li	bert	ytown,	Md.	2170	52	
	20a. METHOD OF DISPOSITION		20b. PLACE AN	DDATEOR	DISPOSITIO	N (Name of		DATE	20c. LOC/	ATION —	City or To	own, State
	1 A Burlet 2 Cremation 3 Ram	oval from State	Restha	ven	Memor	ial Ga	rden	\$10/28	Fre	der	ick.	Md.
- 1	21. SIGNATURE OF PUNERAL SERVICE LIC	CENTIEE AA	1 Kebena	7 011					110		2010,	
- 1		011				D.D.	Har	tzler				
	Vallay S	- LAT						own, M	d.			
	23. PART'I. Enter the diseeses, or o	complications that of	caused the deet	h. Do no	1 enter the	mode of do	ring, auc	h as cardiac	or reaplin	tory ar	rest	Approximate
	shock, or heart failure.	List only one cause	on aech Ilna.							,		Interval Batween
- (IMMEDIATE CAUSE (Finel disease or condition	C		١	r 11	-00	TG	D) <u>_</u>			Onset and Death
	resulting in death)	0	NGES	IIV	6 14	ENIZ	1	MILON	トレ			1 doup
		DUE TO (O	R AS A CONSEOU	ENCE OF)	-0 -		1	07	1.50	- 4	-	/
z I		a A(4	TERIO	SCL	EKOI	ilc t	HEAJ	4	NIDE	P C CA		Dyear
임	Sequentially list conditions, If any, laading to immediate	DUE TO (C)	R AS A CONSEQU	ENCE OF)	:							
		10 (0										
ຽ I	cause. Enter UNDERLYING	c.										
FICA	cause. Enter UNDERLYING	с.	R AS A CONSEOU	ENCE OF)	:							i
RTIFICA	cause. Enter UNDERLYING CAUSE (Disease or Injury	с.	R AS A CONSEQU	ENCE OF)	:							
CERTIFICA	cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events	с.	R AS A CONSEOU	ENCE OF)	:							
	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significent condition	DUE TO (O	eath but not res			rlylng ceuse	given in	Part 1. 24	a. WAS AN A		246	WERE AUTOPSY FINDINGS
	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significent condition	DUE TO (O	eath but not res			rlying ceuse	given in		PERFORM	ED?	241	AMILABLE PRIOR TO COMPLETION OF CAUSE
EDICAL	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significent condition	cDUE TO (O	eath but not res			rlying ceuse	given in			ED?	240	AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?
MEDICAL	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significent condition PART II. Other significant condition	c. DUE TO (0 d. The contributing to de	eath but not res	Buiting in	the under			1	PERFORM	ED?	248	AMILABLE PRIOR TO COMPLETION OF CAUSE
MEDICAL	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significent condition DID TOBACCO USE CONT	c. DUE TO (0 d. The contributing to de	eath but not res	H YES	the under	O UN	given in	1	PERFORM	ED?	248	AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?
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MEDICAL	Cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significent condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL	c. DUE TO (0 d. The contributing to de	SE OF DEAT	H YES	the under	D UNO	CERTAI	1	PERFORM	ED?	246	AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?
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E COMPLETED BY PHYSICIAN: MEDICAL	Cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significent condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Naturel 5 Pending Investigation 3 Suicide 8 Could not be datarmined 29e. CERTIFIER (Check only 1 CERTIFYING PHYS)	RIBUTE TO CAU HOSPITAL: 1 Inpatiant 2 E 288. DATE OF In (Month, Day, 288. PLACE OF building, at	SE OF DEAT 26. PLACE ER/Outpetlent 3 [INJURY At home. (Specify) by knowledge, deat	H YES OF DEATH DOA 28b. TIME INJU	of the under the	Home 5 F C. INJURY AT WORK? Office data end place don, death occur	CERTAII	6 Other (S) 28d. DESCRI 28f. LOCATIC City or 76	PERFORM YES 2 Decity) BE HOW IN. ON (Street endown, State)	JURY OC	r or Rural	AMALABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO Route Number,
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BE COMPLETED BY PHYSICIAN: MEDICAL	Cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significent condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 Yes 2 NO 27. MANNER OF DEATH 1 Naturel 5 Pending Investigation 3 Suicide 4 Homicide 8 Could not be datarmined 29. CERTIFIER (Check only one) 2 MEDICAL EXAMINE	C. DUE TO (O	SE OF DEAT 26. PLACE ER/Outpetlent 3 INJURY Year) INJURY — At hom c. (Specify) by knowledge, deat mination and/or im	H YES OF DEATH DOA 28b. TIME INJU e, farm, st h occurred veatigation 27) (Type,	NC I (Check only) 1 (Check on	D UNICONE) J Home S F C. IMJURY AT WORK? I YES 2 office deta end plac ion, death occur 29c. Life	CERTAII Residence NO No e, end due ured at the CENSE NU 2	6 Other (S) 28d. DESCRI 28f. LOCATIK City or Ti	PERFORN YES 2 Decity) Decity) BE HOW IN. On (Street endown, State) a) and manner of place, and	JURY OC d Number as ata due to i'	r or Rural red. he couse(AMALABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO Route Number,
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION	Cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significent condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 8 Could not be 4 Homicide datarmined 299. CERTIFIER (Check only One) 2 MEDICAL EXAMINE 29b. SIGNATURE AND TITLE OF CERTIFIER	C. DUE TO (O d	SE OF DEATI 26. PLACE ER/Outpettent 3 [IJURY Year) INJURY — At home. (Specify) by knowledge, deat mination and/or im	H YES OF DEATH DOA 26b. TIME INJU e, farm, st h occurred vestigation	NC I (Check only) 1 (Check on	D UNICONE) J Home S F C. IMJURY AT WORK? I YES 2 office deta end plac ion, death occur 29c. Life	CERTAII Residence NO No e, end due ured at the CENSE NU 2	6 Other (S) 28d. DESCRI 28f. LOCATIK City or Ti	PERFORM YES 2 Decity) BE HOW IN. ON (Street endown, State)	JURY OC d Number as ata due to i'	r or Rural	AMALABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO Route Number,
BE COMPLETED BY PHYSICIAN: MEDICAL	Cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significent condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 8 Could not be datarmined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINE 29b. SIGNAFURE AND TITLE OF CERTIFIER 30. NAME AND NDDRESS OF PERSON WHITE CONTROL (CANTIFIER OF CERTIFIE	C. DUE TO (O d	SE OF DEAT 26. PLACE ER/Outpetlent 3 INJURY Year) INJURY — At hom c. (Specify) by knowledge, deat mination and/or im	H YES OF DEATH DOA 26b. TIME INJU e, farm, st h occurred vestigation	NC I (Check only) 1 (Check on	Home 5 F C. INJURY AT WORK? Office data end place don, death occur	CERTAII Residence NO No e, end due ured at the CENSE NU 2	6 Other (S) 28d. DESCRI 28f. LOCATIK City or Ti	PERFORN YES 2 Decity) Decity) BE HOW IN. On (Street endown, State) a) and manner of place, and	JURY OC d Number as ata due to i'	r or Rural red. he couse(AMALABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO Route Number,



31. DATE FILED (Month, Day, Year)

OCT 2 3 1995

32. REGISTRAR'S SIGNATURE

	1. DECEDENT'S NAME (First, Middle, Las				ICATE				2. DATE	OF DEATH	AY	YEAR 3.	TIME OF DEATH
	Mary C								October 21, 199				6:00 A
	213-20-2478	5. SEX	1 □ M 2 🕱 F 73 Y				MIN,	(Month, Day, Year)			e. BIRTHPLACE (State or Foreign Country) 921 Maryland		
~	9a. FACILITY NAME (If not institution, give	9b. CITY, T	TOWN D	R LOCATI	ON OF D	EATH			TY OF DEAT				
DIRECTOR	720 FOXBOW Drive	9			Bel	Air	2			0 1-1	Har	ford	
EC	10a. STATE 10b. COU	ITY		t0c. CIT	Y, TOWN OR	LOCAT	ION					10	d. INSIDE CITY
AL DIF	Maryland Hai	ford		Be	el Air		ZIP COD				La oran	t	LIMITS? YES 2 XI T COUNTRY?
RA	720 Fox Bow Drive					101.	210				200	USA	COUNTRY
BY FUNER	11. MARITAL STATUS t Nover Married Married 3 Wildowed 4 Divorced	NT EVER IN U.S. A 1 YES 2 X WAR OR DATES		14 1	yes, spe	ENDENT C	OF HISPAI	in, Puerto I	17 (Specify Yes Rican, etc.)		14. RACE	American India	
ED E	15. DECEDENT'S EI			USUAL OCC				16b	. KIND OF BUS	SINESS/INDU		White	
H	(Specify only highest gra	de completed) College (1-4 or 5	1/6	Bive kind of the Do NOT us	work done du se retired.)	iring mos	st of working	ng					
COMPLET	12			iomema	ker					Home			
000	17. FATHER'S NAME (First, Middle, Last)						18. MOTI	HER'S NA	ME (First, I	Aiddle, Maiden	Surname)		
BE	John Thomas Will	.S					Mai	rgare	et (r	nmn)	Hamil	ton	
TO E	19a. INFORMANT'S NAME (Type/Print)									oer, City or Tow		Code)	
	John James Roll:	nger, Sr	. 7	20 Fc	ox Bov	v Dr	., E	Bel 2	Air,	Maryla	and 2	21015	
	20a. METHOD OF DISPOSITION 11 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	movel from State	cemeter, A	RISENS	Property Control of the Control of t	rik'	H'CE	MET	ERYPAT	20c. L9	BOL A	ORE;	MD arylan
	* Helly K	Mon	as		131	17 (Cokes	sbur	y Roa	AcComa ad 1 210		eral	Home
	23. PART I. Enter the diseases, o shock, or heart failure IMMEDIATE CAUSE (Final disease Dr condition resulting in death)	at caused the duse on each lin	a.	HEA	RT	FA	140	RE		ratory arre	at,	Approxime Interval Ba Onset and	
			RHEUMATIC HEART DISEASE										
TION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING		CONSEQUENCE OF):										
	CAUSE (Disease or injury that initiated events	c. DUE TO	O (DR AS A CONSE	DUENCE O	F):								
RTIFICA	resulting in death) LAST					erlylno	Cause (olven in	Part I.	24s. WAS AN	AUTOPSY	24h W	THE AUTOPSY FIL
AL CERTIFICATION	resulting in death) LAST	ons contributing to	deeth but not	resulting	In the unde					PERFOR	MATERIA		MPLETION DF C
MEDICAL C										1 TYES 2		Of	DEATH?
MEDICAL C	PART It. Other significant conditions of the part of t	HEAR					ACE OF D	EATH (Ch	eck only on	1 PYES 2		Of	DEATH?
SICIAN: MEDICAL C	PART It. Other significant conditions of the con	HOSPITAL:		PASE		28. PL				1 YES 2		Of	
Y PHYSICIAN: MEDICAL C	PART It. Other significant conditions of the significant condition	HOSPITAL: 1 Inpetient 2 28a. DATE D (Month, I	DISE	3 DOA	OTHER: 4 Nursin E OF 2	28. PL.	5 DKR	sidence	6 Othe	1 YES 2	(SENO	1	DEATH?
ED BY PHYSICIAN: MEDICAL C	PART It. Other significant conditions of the property of the p	HOSPITAL: 1 Inpellent 2 28a. DATE D (Month, 1) 28a. PLACE	□ ER/Outpatient	3 DOA	OTHER: 4 Nursin	28. PL. ing Home tec. INJU WOI 1 Y	JRY AT RK?	sidence	6 Othe	1 YES 2	NJURY OCCU	Of 1	DEATH?
D BY PHYSICIAN: MEDICAL C	PART It. Other significant conditions of the part it. Other significant conditions of the part it. Other significant conditions of the part it. Other part i	HOSPITAL: 1 Inpetient: 28a. DATE 0 (Month, 28a. PLACE building	DISE ER/Outpatient FINJURY Day, 'ber' OF INJURY — Al h, etc. (Specify) If my knowledge, d	3 DOA 28b. TIM INJ ome, farm, seath occurre	OTHER: 4 Nursin E OF URY M street, factor	28. PL. ng Home 18c. INJU WOI 1 Y ry, office	5 XRs	NO NO	6 Othe 28d. DES 28f. LOC City	To YES 2 (Specify) (CRIBE HOW II (Street a or Yown, State)	NJURY OCCL	JRED JRED Ar Rural Flouid	DEATH? YES 2 N

DHMH-18 Rev 1/8

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FENDING PHYSICIAN. The law requires that the death certificate be executed writhin Z4 hours after death. Page 6 may be retained by the hospital or attending physician.	TOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit, Pages 1,	s after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	n 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HOSPITAL DR ATTENDIN	THE FUNERAL DIREC	be filed within 72 hours after dea	Iten
- -	_)	

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 9:45 amps tsor 10 5 P 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH IF UNDER I YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign HOURS 1 🔯 M 2 🗌 F 327-22-3821 YRS. Aug. 6, Missouri 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Shady Grove Adventist Hospital Rockville Montgomery RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Germantown Montgomery 1 YES 2 X NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 19101 Partridgewood Drive 20874 United States 11. MARITAL STATUS 12. WAS OECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yes, specify Cuben, Maxican, Puarto Ricen, etc.) 14. RACE - American Indian, Black, White, etc. 1 Never Married 2 Married 1 YES 2 XNO Specify Specify: BY 3 Widowed 4 Divorced Korean White ETED 15. DECEDENT'S EDUCATION 18a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) COMPL 2 Meteorologist United States Navy 17. FATHER'S NAME (First Middle Lest) 18. MOTHER'S NAME (First, Middle, Malden Surname) James Samuel Robertson Lillian Frances Dugan BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code, 5 19101 Partridgewood Drive, Germantwon, MD 20874 Eileen Iris Robertson 20e. METHOD OF DISPOSITION
1 Burlet 2 Cremetton 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION — City or Town, State 4 Donation 6 Other (Specify) Metropolitan Crematory 10/24/95 Alexandria, Virginia 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY DeVol Funeral Home 10 East Deer Park Drive Gaithersburg, MD 20877 Michael 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest, abock, or heart failure. List only one cause on each line. Interval Between Onset and Death IMMEDIATE CAUSE (Finel disease or condition_ Cancel 12 months UNG reaulting in death) DUE TO (OR AS CONSEQUENCE OF CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) If any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated eventa resulting in death) LAST PART il. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part i. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL PERFORMED? AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? t TYES 2 NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 28. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL HOSPITAL OTHER:
4 Nursing Homa 5 Residence 6 Other (Specify) 113 Ippatient 2 | ER/Outpatient 3 | DOA t TYES 2 NO 28a, DATE OF INJURY (Month. Day, Year) 27. MANNER OF DEATH 28b. TIME OF 28c. INJURY AT WORK?

1 YES 2 NO 28d. OESCRIBE HOW INJURY OCCURED 1 Natural
2 Aceident
3 Suicide 5 Pending Investigation 26e. PLACE OF INJURY — At home, ferm, street, factory, office building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) ETED. 8 Could not be 4 Homicide 29a. CERTIFIER CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2/ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(e) and manner as stated. 296. BIGNATURE AND ATTLE DE CER 29d. DATE SIGNED (Month Ŏ 30. NAME AND A ORESS OF PERSON WHO COMPLETED PAUSE OF DEATH (ITEM 27) (Type, Print)

32. REGISTRAR'S SIGNATURE 31. DATE FILEO (Month, Day, Year) 2 7 1995

DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

		HEGISTRAN				CENT	FICAI	EUT	DEA	<u> </u>		REG. NO.				
		1. DECEDENT'S NAME (First, GEORGE	Middle, Last) COOPE	R REEVE	S							BER 1	7, 19	95	3. TIME OF DEATH 1700 M	
D		4. SOCIAL SECURITY NUMB 565-16-749		5. SEX	6. AGE (in yrs. lest birthde 87 YRS	MONTHS	DAYS	IF UNDER	24 HRS. MIN.	July	28,	1908 e. BIRTHPLACE (State or Foreign founts)		LACE (State or Foreign	
3 should		Se. FACILITY NAME (If not institution, give street and number)					9b. CIT	Y, TOWN	OR LOCATIO	ON OF DE	EATH		9c. COU	NTY OF DE	ATH	
N,	СТОВ	Washington	Adve	ntist Ho	spita	a1	TAKOMA PARK, MARYLAND				ND	MONTGOMERY				
physician. burial-transit permit. Pages 1,	DIRE	Maryland Montgomery				10c. (10c. CITY, TOWN OR LOCATION Silver Spring						10d, INSIDE CITY LIMITS? 1 YES XIX NO			
nsit perm	FUNERAL	100. STREET AND NUMBER 8505 Springvale Road					101. ZIP CODE 20910						10g. CITIZEN OF WHAT COUNTRY? United States			
를 를	B	11. MARITAL STATUS 1 Never Married 2 XX 3 Widowed 4 Divor		12. WAS DECEDEN FORCES? 1 IF YES, GIVE W UNKI	T EVER IN X X YES MAR OR DA NOWN	U.S. ARMED 2 NO ATES	S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yell If yes, specify Cuben, Maxican, Puerlo Rican, etc.) 1 YES A NO Specify:					(Specify Yearican, etc.)	a or No- 14. RACE — American Indian, Black, White, atc. Specity: White			
	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) College (1-4 or 5 +)				16a. DECEDENT	'S USUAL (OCCUPATION MICHAEL	ON ost of workin	ia	18b.	KIND OF BUS	INESS/IND	USTRY			
spital o	COMPLE	Elementary/Secondary (0-		College (1-4 or 5	5	Ille. Do NO	omist)	out of World			Unit	ed S	tates	es Government	
by the	ш	17. FATHER'S NAME (First, Mile Charles		Alva		Reev	es		18. MOTH		ME (First, M	iddle, Malden				
be retained ge 5 should e notified	TO B	19a. INFORMANT'S NAME (Ty. Sylvia Reev	,	ane								Mary1		^{Code)}	70	
age 6 may be director, page er must be		20e. METHOD OF DISPOSITION 1 Burlel 2A Cremation 3 Removal from State 4 Donation 6 Other (Specify)					ACEAND DATE OF DISPOSITION (Name of try, cremetory or other place) ACEAND DATE 20c. LOCATION — City of Town, State 20c. LOCATION — City of Town, State Alexandria, Virginia									
death. Page funeral din I. examiner		21. SIONATORE OF FUNERAL	SERVICE LIC	ENSEE		A i	22 I	onal	ND ADDRES	Bor Bor	qward	it Fun	eral	Home	P.A.	
after by the smova		23. PART I. Enter the dis	CON I	omplications the	2AC t coused	the death. Di									Md. 20705	
within 24 hour spletely filled in cremation, or rent, the me		immediate Cause (Find disease or condition resulting in death)	ert foliure. I	DUE TO	OR AS A	CONSEQUENCE	Fai	In	66						Interval Between Onset and Death SEVERIAL	
and and mati	CERTIFICATION	Sequentially list condition if any, leading to immed cause. Enter UNDERLY!	NG	BILAT	TERAL PHEUMONITIS, AND CONFESTIVE D (OR AS A CONSEQUENCE OF): HEART FAILURE.											
eath certificate be attending physician trai Hygiene prior to y, or other traur	ERTIF	that initiated events resulting in death) LAST		DUE TO	(OR AS A	CONSEQUENCE	OF):				_					
the at Ment		PART II. Other algorificer	nt conditions	contributing to	death bi	ut not requition	In the u	nderivin	O COURA O	lven in	Part I	24. WHC AN	ALITODOV	245	WERE ALTONOV PRIDINGS	
uires that the dea signed by the ati Health and Menta we amy Injury,	EDICAL	PART II. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Part I. OKSTEMIC LUPUS ENTHEMATOSUS 2 NENALFAILVIL 1 YES 2 NO COMPLETION OF CAUSE DEATH? OGASTROINTEST HAL BLELDING														
Do un of	Σ														1 - YES 2 1 NO	
law lept 23	AN	DID TOBACCO US		SIBUTE TO CA		F DEATH		NO P	∆ UNC	ERTAIN	1 🗆					
SICIAN: The certificate h the State (1, or item)	YSICIAN:	EXAMINER? 1 YES 2 NO	MEDICAL	HOSPITAL:			OTHE	R:	ne 6 🗆 Ra	sidence	6 🗆 Other	(Specify)				
NG PHYSIC fler this ce sath with ti marked,	ву рну	27. MANNER OF DEATH 1 Natural 5 P 2 Accident	Pending nvestigation	28a. DATE OF (Month, D			ME OF JURY M	28c, INJ WC	JURY AT ORK? YES 2	ho	28d. DESC	RIBE HOW IN	JURY OCC	URED		
TOR: A after do		3 Suicide 8 C	Could not be etermined	28a. PLACE O building,	F INJURY etc. (Speci	— At home, farm	, atreet, fac	tory, offic	:8			TION (Street a Town, State)	nd Number	or Rural Ro	ute Number,	
AL DIR	COMPLETED			CIAN: To the best of											and manner as stated.	
TO THE HOSPIT TO THE FUNERA De filed within 7	BE	29b. SIGNATURE AND TITLE (4. Mar	m	an r	ND		29c. LICE						Month, Day, Year)	
\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	2	30. NAME AND ADDRESS OF	PERSON WHO	COMPLETED CAUS	E OF DEA	THUTEM 23 P	PRA?	WD		715		HOD		TAIN	DAVE	
		31. DATE FILED (Month, Day, X		32. REGISTRA	R'S SIGNA	Kardall			M	IOUR	AT U	-AINI	EL	MD.	20712	

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TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	FOR 1 - STATE REGISTRAR	STATE OF MARYLA		IENT OF HEALTH A ATE OF DEATH		ITAL HYGIENE				
	1. DECEDENT'S NAME (First, Middle, Last)	ARTHUR		WALDT	2. [PATE OF DEATH	P 20 1	EAR	1240 pm	
	4. SOCIAL SECURITY NUMBER 5.	SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BI								
	101 10 2313	30							ma	
œ	Se. FACILITY NAME (If not institution, give street	and number)		L CITY, TOWN OR LOCATION	OF DEATH		9c. COUNTY	OF DEATH		
DIRECTOR	Suburban Hospital		B	ethesda			Mont	gomery	7	
E	10a. STATE 10b. COUNTY	10c. CITY, T	OWN OR LOCATION					NSIDE CITY		
	none none		Wasl	nington, D.C					YES 2 NO	
ĭ.	10e. STREET AND NUMBER			10f. ZIP COOE			10g. CITIZEN	OF WHAT C	OUNTRY?	
FUNERAL	4417 49th Street,			20016				S.A.		
5	1 Never Married 2 X Married	2. WAS DECEDENT EVER IN I FORCES? 1 T YES	2 NO	13. WAS DECENDENT OF If yes, specify Cuban,			or No- 14,	RACE - Am Black, White	ericen Indian, i, etc.	
B	3 Widowed 4 Divorced	1962-1964	ES	1 TES 2 X NO	Specify:			Specify: vhite		
	15. DECEDENT'S EQUCAT	ION	16a. DECEDENT'S US			16b. KIND OF BUSI				
	(Specify only highest grade con Elementary/Secondary (0-12)	npleted) College (1-4 or 5 +)	(Give kind of work life. Do NOT use re	done during most of working kired.)						
COMPLETED		4	photogra	apher		self-	employ	/ed		
ő	17. FATHER'S NAME (First, Middle, Last)			18. MOTHE	R'S NAME (F	irst, Middle, Meiden S	Surname)			
BE (Charles Arthur	Rehaldt		He1	en We	lch				
10	19a. INFORMANT'S NAME (Type/Print)		19b. MAILINO AC	ORESS (Street and Number or	Rural Route	Number, City or Town,	, State, Zip Coo	de)	1015	
	Helen Frances			9th St., N.W.	,Wash					
	20a. METHOD OF DISPOSITION 1 Disposition 3 Remove	I from State cemei	tery, crematory or other	DISPOSITION (Name of place)			ATION — City			
	4 Donetton 5 Other (Specify) 21. SIGNATURE OF EUNERAL SERVICE LICEN	Me	tropolit	an Crematory	Oct	22,95 A	lexand	ria.	Va.	
	000	2000		DeVol Funer						
	ame an	35 VEF		2222 Wiscon	sin A	ve.,N.W.	.Wash.	DC 2	.0007	
	23. PART Enter the diseeses, or con shock, or heart feliure. Lia	nplications that caused it only one cause on ear	the desth. Do not ch line.	enter the mode of dying	g, such ss	cerdisc or respir	atory erreat		Approximeta Interval Batwean	
	IMMEDIATE CAUSE (Finel	11	- 1110	0~1.	1 0				Onset and Death	
	disease or condition → a. ISCHEMIC COLITIS									
_	DUE TO (OR AS A CONSEQUENCE OF):									
S	Sequentially list conditions, DuE TO (OR AS A CONSEQUENCE OF):									
Ä	If any, leading to immediate cause. Enter UNDERLYING									
Ĕ	CAUSE (Disease or injury that initiated events	DUE TO (OR AS A	CONSEQUENCE OF):							
CERTIFICATION	resulting in death) LAST									
	PART II. Other eignificent conditions of	contributing to deeth bu	t not resulting in	the underlying cause giv	ven in Part	I. 24a, WAS AN A	NITOPSY	24b WERE	AUTOPSY FINDINGS	
CAL		,		and disconjung dodge gre		PERFORI	MED?	AVAILA	ABLE PRIOR TO LETION OF CAUSE	
						1 TYES 2	NO NO	OF DE	EATH?	
PHYSICIAN: MEDIC	DID TOBACCO USE CONTRIE	BUTE TO CAUSE OF	DEATH YES	□ NO □ UNCE	RTAIN	zi			YES 2 NO	
A	25. WAS CASE REFERRED TO MEDICAL		6. PLACE OF DEATH							
Sic		IOSPITAL: X Inpetient 2 - ER/Outpe	tient 3 DOA 4	THER: Nursing Home 5 Rasi	dence 8 🗆	Other (Specify)				
并	27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME C		280	. DESCRIBE HOW IN	JURY OCCUR	EO		
ВУ	1 Natural 5 Pending 2 Accident Investigation	(, 5.4), 15.27)		M 1 YES 2	NO					
	3 Sulcide 8 Could not be	28s. PLACE OF INJURY - building, etc. (Specif	— At home, farm, atre	et, lactory, office	281	LOCATION (Street as City or Town, State)	nd Number or I	Rural Route N	umber,	
	4 Homicide determined									
7		AN: To the best of my knowle	dge, death occurred	it the time, data and place, a	ind due to th	e cause(s) and man	ner sa stated.			
COMPLETED	one) 2 MEDICAL EXAMINER:	On the basis of examination	and/or investigation,	In my opinion, death occured	d at the time.	, data and place, and	dua to the co	auee(a) and r	nanner as stated.	
BEC	29b. SIGNATURE AND TITLE OF CERTIFIER	CM 1		29c. LICEN	SE NUMBER		29d. DATE SI	IGNED (Month	1, Day, Year)	
5 B	3 Kido	my MID		124	655)	▶ 10	1211	15	
-	30. NAME AND ADDRESS OF PERSON WHO E SUJATHA READ	Y. SURURBI	120H WF	TAL, 860	D OL	D GEOR	GUE TOI	DNR	D, MD	
	31. DATE FILED (Month, Day, Year)	32 REGISTRAR'S SIGNA	TUNE 1-11							
	OCT 25 1995	States Davisson	REPORTE							

9c. COUNTY OF DEATH

MONTGOMERY

10g. CITIZEN OF WHAT COUNTRY?

UNITED STATES

14. RACE — American Indian, Black, White, atc.

Specify: WHITE

3. TIME OF DEATH

CZECHLOSOVAKIA

10d. IHSIDE CITY

LIMITS? X

Interval Between

24b. WERE AUTOPSY FIHDINGS

AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?

1 YES 2 HO

29d. DATE SIGHED (Month, Day, Year)

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8. BIRTHPLACE (State or Foreign

2. DATE OF DEATH

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REGISTRAR

Ruth

1. DECEDENT'S HAME (First, Middle, Last)

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4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. lest birthday) 5. SEX IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH DAYS MAY" 22, "00" 1935 1 M 2 X F 60 102-34-3190 YRS 9e. FACILITY HAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR Pages 1, 2, 3 11604 FULHAM STREET SILVER SPRING RESIDENCE OF DECEDENT 10a. STATE 10b. COUHTY 10c. CITY, TOWN OR LOCATION MARYLAND MONTGOMERY SILVER SPRING permit. FUNERAL 10a. STREET AND HUMBER 101 ZIP CODE 11604 FULHAM STREET 20902 and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit o burial, cremation, or removal. Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMEO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or NoIf yes, specify Cuban, Maxican, Puerto Rican, etc.) FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 1 Never Married 2 Merried BY 1 YES 2 X NO Specify 3 Widowed 4 Divorced ETED 15. DECEDENT'S EDUCATION 16a. OECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 18b. KINO OF BUSINESS/INDUSTRY (Specify only highest grade College (1-4 or 5 +) 5+ Elementary/Secondary (0-12) COMPL NURSE HEALTH CARE once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S HAME (First, Middle, Malden Surname) notified at REUBEN STERN GABRIELLA ROSENBAUM BE 19a. IHFORMANT'S HAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 HARVEY RICE (HUSBAND) 11604 FULHAM STREET - SILVER SPRING, MD. 20902 e 20e. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE must 1 Suriel 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) MT. LEBANON CEMETERY 10/23 FLUSHING, NEW YORK examiner 21. SIGNATURE OF FLINEBAL SERVICE LICENSEE 22. HAME AHD ADDRESS OF FACILITY executed within 24 hours after death. DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE-ROCKVILLE, MD. 20852 medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdisc or respiratory arrest, shock, or heart failure. List only one cause on each line. **IMMEDIATE CAUSE (Final** he disesse or condition metastasis + Lung metastasis resulting in death) event Breast Cancer traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): prior to if sny, leading to immediate cause, Enter UNDERLYING the attending physician Mental Hygiene prior to other t CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in dasth) LAST 0 Injury, PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part i. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? signed by the any 1 YES 2 NO DIRECTOR: After this certificate has been hours after death with the State Dept. of Item 28 is marked, or Item 23 sho DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO W UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) OR ATTENDING PHYSICIAN: The EXAMINER? HOSPITAL: OTHER-1 YES 2 NO 1 | Inpatient 2 | ER/Outpetient 3 | DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 28e. DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED INJURY 1 Natural 5 Pending Investigation M 1 YES 2 NO BY 2 Accident 26s. PLACE OF INJURY — Al home, farm, streat, factory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Flural Floute Number, City or Town, State) ETED 6 Could not be 4 Homicide COMPL 1 CERTIFYINO PHYSICIAN: To the best of my knowledge, death occurred at the lime, date and place, and due to the cause(s) and manner se stated. TO THE HOSPITAL OF TO THE FUNERAL D DE filed within 72 ho (Check only one) HOSPITAL 2 MEDICAL EXAMINER: On the of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(e) and manner as stated SHUMATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE walde (MD) 10/21/95 D22101 2 MALE AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) A. Vander Walde 5100 Auth Way Suitland MD 22746

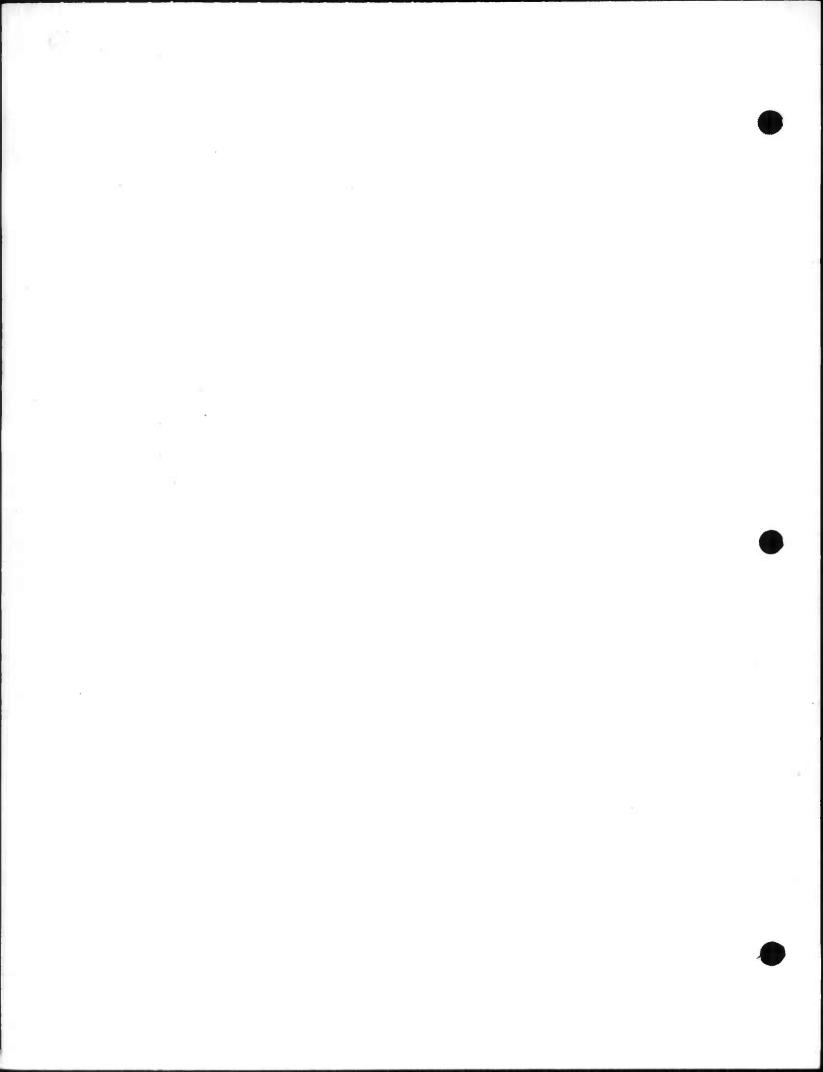
> 32. REGISTRAR'S SIGNATURE a Davidson Revolate

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

31. OATE FILED (Month, Day, Year)

1995



STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

JACK RATZKIN

26 1995

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1 XX 2 - F

4. SOCIAL SECURITY NUMBER

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use as the burial-transit permit. Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give stre 9b. CITY, TOWN OR LOCATION OF DEATH SUBURBAN HOSPITAL DIRECTOR BETHESDA RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION FLORIDA BROWARD POMPANO BEACH FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 1350 NW 48TH PLACE 33064 retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 XNO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-If yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 1 Never Merried 2 Merried BY 3 Widowed 4 Divorced ETED 16e. DECEDENT'S USUAL OCCUPATION
(Che kind of work done during most of working 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high (Give kind of work done life, Do NOT use retired.) P Elementery/Secondary (0-12) College (1-4 or 5+) COMPL 12 MECHANICAL ENGINEER detached FEDERAL GOVERNMENT once. 17. FATHER'S NAME (First Middle Last) 16. MOTHER'S NAME (First, Middle, Melden Surneme) MAX RATZKIN 2 to IDA "UNKNOWN" page 5 should notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, Stets, Zip Code) 2 EDITH RATZKIN (WIFE) 1350 NW 48TH PLACE-POMPANO BEACH, FLORIDA 33064 24 hours after death. Page 6 may be pe 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION - City or Town, State must funeral director, cemetery, crematory or other place) KING DAVID 10-27 FALLS CHURCH, VIRGINIA examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE, NAME AND ADDRESS OF FACILITY DANZANSKY-GOLDBERG MEMORIAL CHAPELS INC. ble 1170 ROCKVILLE PIKE-ROCKVILLE, MARYLAND 208\$2 n by the removal. medical filled in by t 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ehock, or heart fellure. List only one cause on each line. IMMEDIATE CAUSE (Final the cremation. disease or condition neumonia pletely reaulting in death) event. DUE TO (OR AS A CONSEQUENCE OF): m00 buriat. executed traumatic CERTIFICATION and Sequentially list conditions, ung physician and Hygiene prim if any, leeding to immediate cause. Enter UNDERLYING 8 other t CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF that initiated eventa the attending p d Mental Hygien reaulting in death) LAST 10 PART II. Other aignificent conditions contributing to death but not resulting in the underlying ceuse given in Part i. 24s. WAS AN AUTOPSY MEDICAL the has been signed by Dept. of Health and PERFORMED? any 1 YES 2 NO Shows DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO 21 UNCERTAIN I PHYSICIAN: 23 26. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL this certificate h EXAMINER? HOSPITAL: 1 Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 8 Other (Specify) 50 27. MANNER OF DEATH 28e. OATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 26d, DESCRIBE HOW INJURY OCCURED marked, 1 Natural 0 THE HOSPITAL DH MILLELL TO THE FUNERAL DIRECTOR: After this be filed within 72 hours after death wither PRTANT: If Item 28 Is mark 5 Pending Investigation 1 YES 2 NO BY 2 Accident 26e. PLACE OF INJURY — At home, ferm, street, fectory, office building, etc. (Specify) 3 Suicide 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) ETED. 6 Could not be 4 Homicide 29e. CERTIFIER
(Check only one)

2 MEDICAL EXAMINES: On the basis of my knowledge, death occurred at the time, date end place, and due to the cause(e) and menner ee stated. COMPL TO THE HOSPITA
TO THE FUNERAL
DE filed within 72
IMPORTANT: If 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occured at the time, date end place, and due to the cause(e) and menner se stated. 29b, SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER H Chalw Bhomler MD D43496 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 1299-Lambeton Deine MOHAMMADA KHALID Talin Dawler Randal 31. DATE FILEO (Month, Day, Year)

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

IF UNDER 1 YEAR

6. AGE (In yrs. lest birthday,

80

YEAR

9c. COUNTY OF DEATH

MONTGOMERY

10g. CITIZEN OF WHAT COUNTRY?

UNITED STATES

3. TIME OF DEATH

:55

8. BIRTHPLACE (State or Foreign

NEW YORK

10d. INSIDE CITY

14. RACE — American Indian, Black, White, atc.

WHITE

interval Retween **Onaet and Death**

S WKS

24b. WERE AUTOPSY FINDINGS

AVAILABLE PRIOR TO

1 YES 2 NO

29d. DATE SIGNEO (Month, Day, Year)

COMPLETION OF CAUSE

1 YES 2X NO

REG. NO

24.

1995

2. DATE OF DEATH MONTH

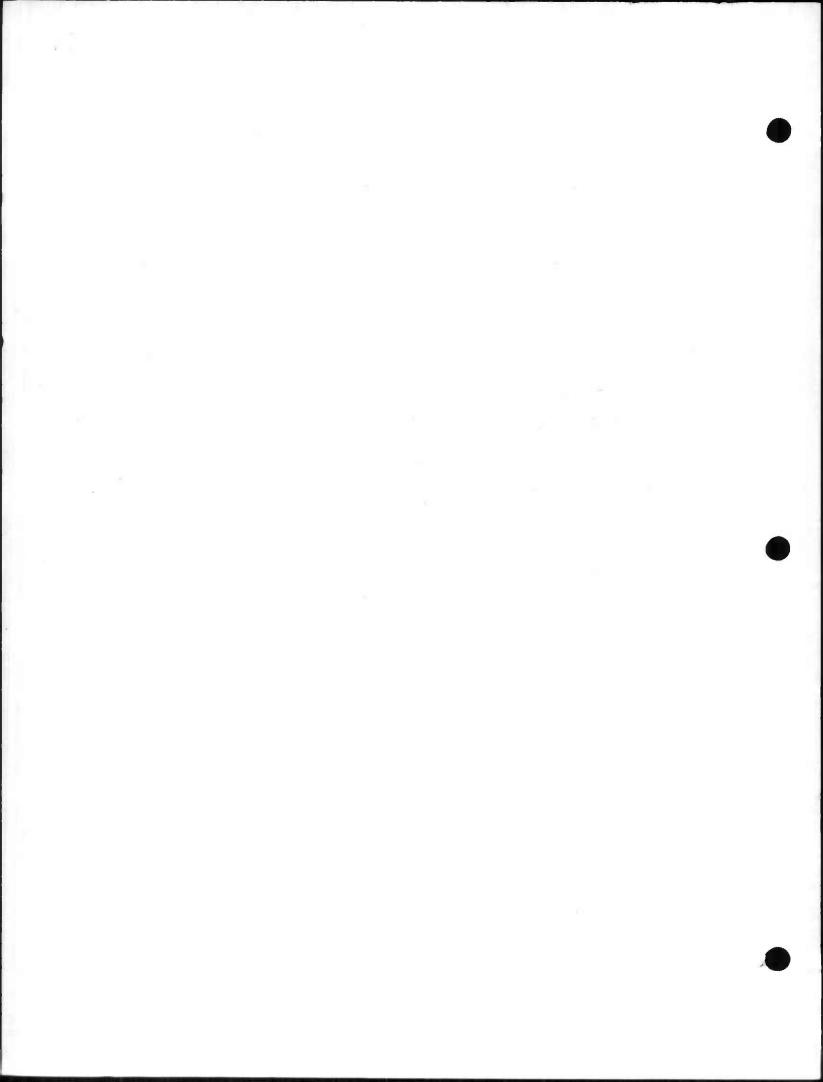
7. DATE OF BIRTH

JAN. 12,

OCT.

IF UNDER 24 HRS.

DHMH-16 Rev 1/89



BALTIMORE, MARYLAND 21215-0020

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OF ALLENDING PHYSICIAN: The law requires that the death certificate be executed whitme 24 hours are recent. Fage to may be retained by	DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should	
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JING	After	nours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal
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Amended items # 1 & 17 WCHD 10/23/94 jrd FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH REG. NO 1. OECEDENT'S NAME (First, Middle, Last) 2. DATE OF OEATH MONTH 3. TIME OF DEATH JAMES YEAR 1995 ROMAN WILLIAM OCT STEINER 1200 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) 6. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR | IF UNDER 24 HRS. 89 213-10-3375 1905 Maryland November 11 9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 32435 OLD OCEAN ROAD WICOMICO PARSONSBURG RESIDENCE OF DECEDENT 10e. STATE 10b. COUNT 10c CITY TOWN OR LOCATION 10d. INSIDE CITY Maryland Wicomico Parsonsburg 1 YES 2 X NO 10e. STREET AND NUMBER FUNERAL 101. ZIP COOE 10g. CITIZEN OF WHAT COUNTRY? 32435 Old Ocean City Rd. USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2XNO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Norried If yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 1 TES 2 NO Specify. Specify-BY 3 Widowed 4 Divorced White ED 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Ш COMPL 12 Builder Construction at once. 17. FATHER'S NAME (First, Middle, Last)
Roman James S Anstett notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADORESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 32435 Old Ocean City Rd., Parsonsburg, MD 21849 Kathryn Steiner must be 20e. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE Buriel 2 Cremetion 3 Removal from State 4 Donattica Salisbury Crematory 10/19 Salisbury, MD 21. SIGNATURE OF FUNERAL SERVICE LICENSEE examiner 22. NAME AND ADDRESS OF FACILITY Holloway Funeral Home 0 501 Snow Hill Rd., Salisbury, MD 21801 CHOCOLUCIA medical 23. PART i. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. interval Batween **Oneat and Death IMMEDIATE CAUSE (Final** the disease pr condition Multiple Injuries resulting in death) other traumatic event, DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST injury, PART ii. Other aignificent conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PERFORMED? AWAS ARLE PRIOR TO shows any apperoscerenz cardiovascular COMPLETION OF CAUSE OF DEATH? 1 TES 2 NO disene 1 YES 2 | NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square PHYSICIAN: Dept. 26. PLACE DF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL HOSPITAL: 1 X YES 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) or or 280. DATE OF INJURY (Month, Day, Year) Faux (10-14-95 28b. TIME OF 27. MANNER OF DEATH 28c. INJURY AT WORK? 26d. DESCRIBE HOW INJURY OCCURED, marked, laun tracky - feil 5 Pending Investigation 1 Netural 10:45 M 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, lerm, street, fectory, office building, etc. (Specify) 261. LOCATION (Street and Number City or Town, State) after de 28 is a 3 Sutcide ETED 6 Could not be 4 🗌 Homicide Home 32435 TO THE HOSPITAL OR ATTO THE FUNERAL DIRECT DE filed within 72 hours a IMPORTANT: If item 2 29e. CERTIFIER (Check only one)

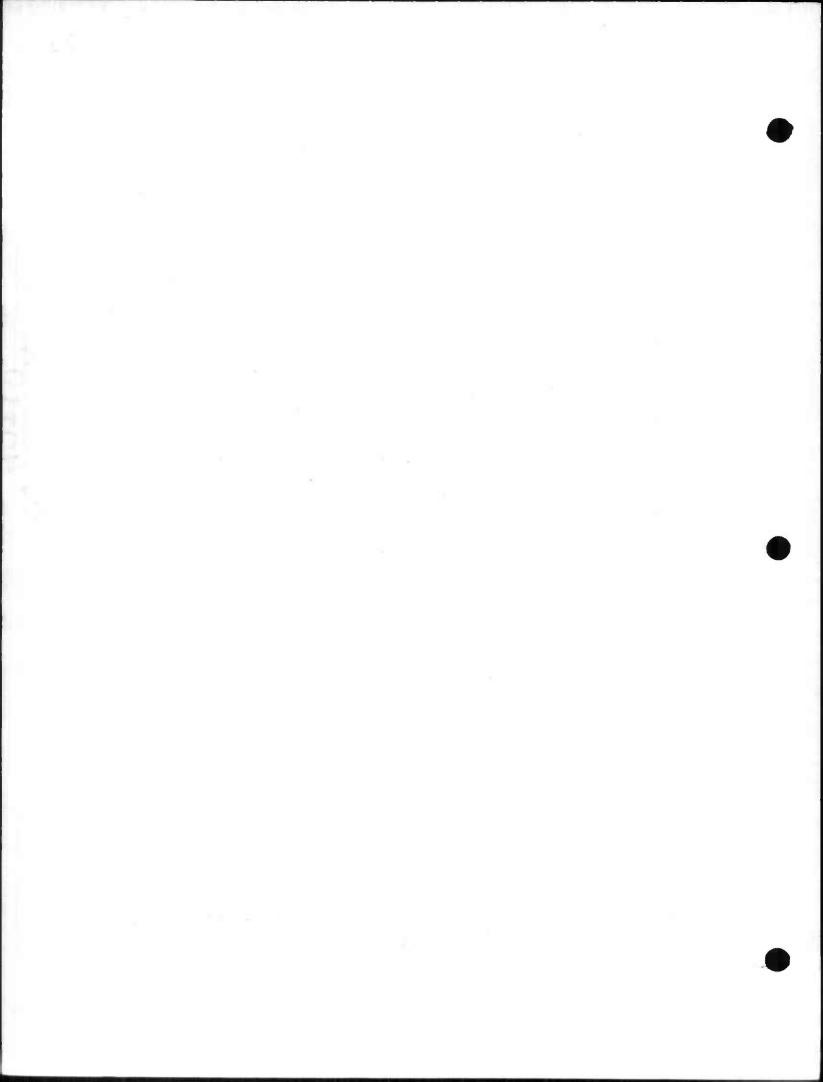
TO STANDING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner as stated. COMPL ZXXMEDICAL EXAMINER: On the besis of exemination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(s) end menner es stated 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) OCT. 15,1995 O.C.M.E 2 30. NAME AND ADDRESS OF PERSON WHD COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Fow ler

32. MEGISTRAR'S SIGNATURE
Jaha Dawelson Randall

31. DATE FILED 4000 Por Year 1995

111 Penn Street, Baltimore, Maryland 21201



TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

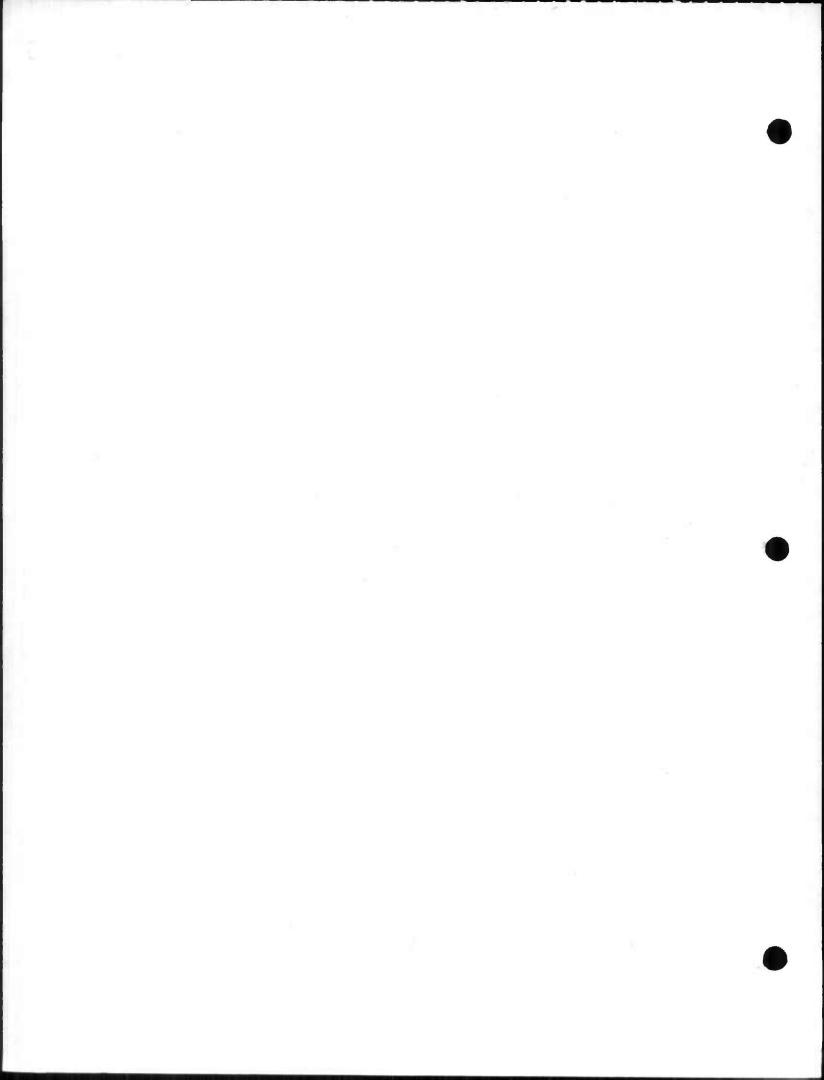
IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR STATE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

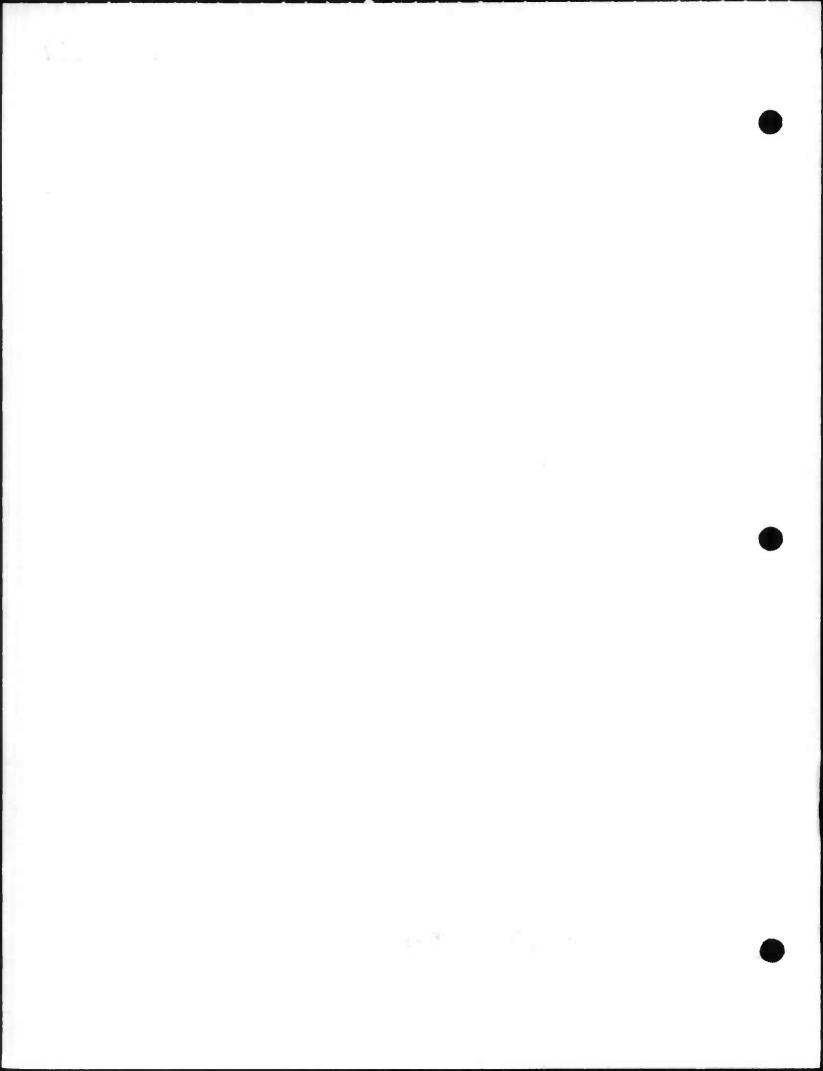
	* REGISTRAR		CE	KIIF	ICALE	OF	DEAL	Н		REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Lest)	FRANCES							2. DATE OF MONTH	DV		YEAR	3. TIME OF DEATH
			TEWART					October 15,1995				9:05 a™	
	4. SOCIAL SECURITY NUMBER		AGE (In yrs. last	//	IF UNDER 1	DAYS	HOURS	4 HRS.	7. DATE OF (Month, D	BIRTH ey, Yber)		8. BIRTH Country	PLACE (State or Foreign y)
	220-10-8492	1 M 2 F	85	YAS.					June 20, 1910				ryland
_	9a. FACILITY NAME (If not institution, give s	treet and number)			9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH							EATH	
9	615 Clyde Ave.				Fr	uit	land				Wi	comic	20
2	RESIDENCE OF DECEDENT 10a, STATE 10b, COUNTY	ν		10c CIT	Y, TOWN OF	B LOCAT	TION						10d. INSIDE CITY
DIRECTOR		comico			Fruit								LIMITS?
	10e. STREET AND NUMBER	Comiteo			rare	-	f. ZIP CODE				10a C17	TIZEN OF V	VNAT COUNTRY?
RA	The state of the s						2 182	6			log. Gr	USA	WALL COOKING
FUNERAL	615 Clyde Ave.				40.14	70.05			IC ORIGIN? (D 14 - M	No		A
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ВУ	3 Widowed 4 Divorced	IF YES, GIVE WAR	OR DATES		1	YES	2∑∑ NO	Specify				Wh i	
	15. DECEDENT'S EDU	CATION	16a. DE	CEDENT'S	USUAL OC	CUPATI	ON		16b. Ki	ND OF BUS	SINESS/IN		
E	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	(Gi	ve kind of v Do NOT us	work done di se retired.)	uring mo	ost of working						
P	10	0	Н	ousev	wife				D	omes	tic		
COMPLETED	17. FATHER'S NAME (First, Middle, Lest)						18. MOTHE	ER'S NAI	ME (First, Mide	die, Maiden	Surname)		
BE C	Nevins Thomas B	enjamin Fo	skey				M	inn	ie		Be	11	
	19a. INFORMANT'S NAME (Type/Print)		198	. MAILING	ADDRESS	(Street	and Number o	or Rural A	loute Number,	City or Tow	n, State, Zi	p Code)	
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	20a. METHOD OF DISPOSITION	0.0000000000000000000000000000000000000	20b. PLACE			TION (N	ame of		DATE	20c. LO	CATION -	- City or To	own, State
	1 Tx Burlal 2 Cremetton 3 Removal from State 4 Donatton 8 Donatton 8 Donatton (Specify) Wicomico Memorial Park 10/19 Salisbury, MD									MD			
	22. NAME AND ADDRESS OF FACILITY Holloway Funeral Home												
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-	36 PART / Enter the diseases, or	complications that	money No of	eth Do r									2 180 1 Approximate
	ehock, Dr heart failure.						or ayın	19, 000	0	о от тоор		· · · · · ·	Interval Between
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EDICAL	PART II. Other algorificent condition	na contributing to de	eeth but not r	eaulting	in the un	deriyin	ig cause gi	iven in	Pert I. 2	PERFO		24b	. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
DIC									_ 1	YES 2	NO □		COMPLETION OF CAUSE OF DEATH?
ME													1 TES 2 NO
	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN												
CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLAC	E OF DEA	TH (Check of	-							
/SI	1 TYES 2 70	t 🗆 Inpatient 2 🗆 E	R/Outpatient 3	□ DOA	4 Num		ne 5X Res	sidenca	8 🗆 Other (S	Specify)			
PHYSICIAN:	27. MANNER OF DEATH	28a. DATE OF IN (Month, Day,		28b. TIN	IE OF JURY		JURY AT ORK?		28d. DESCI	NBE HOW	INJURY O	CURED	
ВУ	1 Netural 5 Pending 2 Accident Investigation				М	1 🗆	YES 2	NO					
ED E	3 Suicide 8 Could not be	28e. PLACE OF building, at		me, term,	atreet, facto	ory, offi	ce			ON (Street Town, State		or Rural i	Route Number,
ETE	4 Homicide determined												
PLE	29e. CERTIFIER (Check only	ICIAN: To the best of m	y knowledge, da	ath occum	red at the ti	me, det	and placa,	and due	to the cause	(s) and ma	nner as at	ated.	
COMPL	CERTIFYING PHYSICIAN: To the beet of my knowledge, death occurred at the time, deta and place, and due to the cause(s) and manner as stated. CERTIFYING PHYSICIAN: To the beet of my knowledge, death occurred at the time, deta and place, and due to the cause(s) and manner as stated.									s) and manner as stated.			
	29b. SIGNATURE AND TITLE CERTIFIE	iR					29c. LICE	NSE NUI	ABER		29d. DA	TE SIGNE	(Month, Day, Year)
H	KC1 0	PAMA					100	05	707		1	6/17	195
5	30. NAME AND ADDRESS OF PERSON WI	HO COMPLETED CAUSE	OF DEATH (ITE	M 27) (Type	s, Print)		1.					1.,	
	140	25 50 Mil	2. 14	56	Con	2 04 1	SI	5	ALISBO	1100 V	M	1 5	1801
	31. DATE FILED (Month, Day, Year)	22 REGISTRAR	S GIGNATURE	01	CATKK	LL	01.	J/	14 11)	are y		V	. 0 - 1
	OCT 1 8 1001	John At	welson Ra	1.11									



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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within FF hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should
be filed within 72 hours after death with the State Dept. or Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPARTM CERTIFIC	MENT OF I	IEALTH AND	MENTAL HYGIEN				
N.	t. DECEDENT'S NAME (First, Middle, Last)				<u> </u>	2. DATE OF DEATH	·	3. TIME OF DEATH		
18	JUNE I. S	SMITH		am	ith	MONTH D	11 199	1515 "		
	4. SOCIAL SECURITY NUMBER	I COSUL II								
	222-18-0493	1 □ M 2XXF 65		NTHS DAYS	HOURS MIN.	(Month, Day, Year)	030	IRTHPLACE (State or Foreign ountry) Oelaware		
	Aug. 13, 1950 Bell									
œ	9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH									
2	PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMIC									
LU 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION										
Delaware sussex Seaford										
									10g. CITIZEN OF WHAT CO	
2	81 Jamore Dr. 19973 US									
2	1 Never Married 2 Married	12. WAS DECEDENT EVER I FORCES? 1 YES	2 X NO	If yea, ap	ENDENT OF HISPA ecity Cuban, Mexico	NIC ORIGIN? (Specify Year, Puerto Rican, etc.)	or No- 14. F	RACE — American Indien, Black, White, atc.		
В	3 Widowed 4 Divorced	IF YES, GIVE WAR OR D	ATES	1 TYES	2 NO Specif	ly:		Specify: White		
	15. DECEDENT'S EDUC	CATION	16a. DECEDENT'S US	IAL COCURATION	241					
	(Specify only highest grade	completed)	(Give kind of work life. Do NOT use n	done during me	st of working	16b. KIND OF BU	SINESS/INDUSTF	TY .		
٦	Elementary/Secondary (0-12)	College (1-4 or 5+)	Homema			Home	Owner			
COMPLETED	17. FATHER'S NAME (First, Middle, Last)		Homema	IKEL						
						ME (First, Middle, Meiden H. King	Surname)			
B	James W. Dunham									
0	19a. INFORMANT'S NAME (Type/Print)	1 1 1	19b. MAILING AD	DRESS (Street a	nd Number or Rural	Route Number, City or Tow	n, State, Zip Code))		
	Jerry L. Smith -	husband	81 Jan	iore Dr	., Searc	rd, De. 19	913			
- 8	20a. METHOD OF DISPOSITION tX Burlet 2 ☐ Cremation 3 ☐ Remo		D. PLACE AND DATE OF D				CATION - City of			
	4 Donalish 5 Other (Specify)		Union Cen		1	.0/14/95 Ge	orgetow	n, De.		
- 8	21. SIGNATURE OF FUNERAL SERVICE LIC	INSEE		22. NAME A	D ADDRESS OF FA	CILITY				
	John A. Cranst	neugus	>			eral Home	D 100	172		
-		amplications that com-	data da de la Companya			Seaford,				
	28. PART I. Enter the diseases, or c shock, or heert fellure. I	List only one cause on e	ach line.	enter the mo	de of dying, suc	th as cerdiac or resp	ratory arrest,	Approximata - Interval Between		
	IMMEDIATE CAUSE (Final							Onset and Death		
	disease or condition resulting in death)	DUE TO (OR AS A	in rieg of	71/5	SEPSIS	,		3 Rous.		
		DUE TO (OR AS A	CONSEQUENCE OF):					7		
z		Multipl	E MUJE	10us				1282		
2	Sequentially liet conditions, if any, leading to immediate	DUE TO (OR AS A	CONSEQUENCE OF):							
HIFICATION	cause. Enter UNDERLYING CAUSE (Disease or Injury									
=	that initiated events	DUE TO (OR AS A	CONSEQUENCE OF):							
	resulting in death) LAST	1,								
5	PART II. Other significent conditions	a contribution to death b								
¥	PART III OTHER SIGNIFICANT CONDITIONS	contributing to deeth b	ut not resulting in t	ne undertyln	cause given in		AUTOPSY IMED?	24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO		
<u> </u>						1 _ YES 2	DY NO	OMPLETION OF CAUSE OF DEATH?		
E								1 YES 2 NO		
BY PHYSICIAN: MEDIC	DID TOBACCO USE CONTR	RIBUTE TO CAUSE O	F DEATH YES	□ NO □	UNCERTAI	N 🗆				
Y	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEATH	Check only one)						
2	t YES 2 No	HOSPITAL: tul Inpetient 2 - ER/Outp		THER: Nursing Hom	e 5 🗆 Residence	6 Other (Specify)				
	27. MANNER OF DEATH	26a. DATE OF INJURY	26b. TIME O	F 28c. INJ	URY AT	28d. DESCRIBE HOW I	NJURY OCCURE			
	Natural 5 Pending	(Month, Day, Year)	INJURY		PK? 'ES 2 NO					
	2 Accident Investigation 3 Suicide & Could and be	28s. PLACE OF INJURY	— At home, farm, stree			26f. LOCATION (Street :	and Number or Bu	rel Boute Number		
3	4 Homicide 6 Could not be	building, atc. (Spec	cify)	, , , , , , , , , , , , , , , , , , , ,		City or Town, State)	ind runnoer or rid	rai rioute regimosi,		
4	29e. CERTIFIER						-			
Ē	(Check only	CIAN: To the best of my know								
29. CERTIFIER (Check only one) 29. MEDICAL EXAMINER: On the basic of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner as stated.										
	29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUI	MBER	29d. DATE SIGI	NED (Month, Day, Year)		
DE	hausy Ceople	W 29 N	17)		D320,	14	10/1			
2			ATH (ITEM 27) (Type, Prin	7()						
	MAHES H MOUNDEA 31. DATE FILED (Month, Day, Year)	+ 547 = RIG	EVSINE	Druis	Saliab	use Mo	2/80	/		
	31. DATE FILED (Month, Day, Year) OCT 16 1995	32 REGISTRAR'S SIGN	ATURE		un la	wey .				
	, , ,, ,, ,,	- John o oldin				V				
	OCT 1 & 100F	dali America	Cal 11					- 1		



STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH
REG. NO.

		REGISTRAR		CER	IFICATE O	PEATH	REG. N	Ю.				
		1. DECEDENT'S NAME (First, Middle, Last) Voyd L. Sp	ence				2. DATE OF DEATH MONTH	DAY	9. TIME OF DEATH			
		4. SOCIAL SECURITY NUMBER					Oct. 5	1995				
				(In yrs. lest birth	MONTHS DAY		7. DATE OF BIRTH (Month, Day, Year)		I. BIRTHPLACE (State or Foreign Country)			
PS		219-60-1697	X	39 YI	RS.	July 03, 1	956 N	Maryland				
3 should	- I	9a. FACILITY NAME (If not institution, give s	street end number)		9b. CITY, TOW	N OR LOCATION OF D	EATH	9c. COUNTY OF DEATH				
23	ECTOR	Deer's Head C	enter		Sali	sbury		Wico	Wicomico			
-		RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT		1		-						
Pages	DIRE			100	CITY, TOWN OR LO				10d. INSIDE CITY LIMITS?			
jį.		Maryland Wico		Fruitland			1)√□ YE					
permit.	¥	10e. STREET AND NUMBER				101. ZIP CODE		10g. CITIZE	EN OF WHAT COUNTRY?			
020 physician. burial-transit	띨	111C Linda Drive.	Apt. 2			21826		US	A			
020 physician burial-trar	J.	11. MARITAL STATUS	12. WAS DECEDENT EVER	IN U.S. ARMED	13, WAS E	ECENDENT OF HISPA	NIC ORIGIN? (Specify	fee or No- 1	4. RACE — American Indian, Black, White, etc.			
1215-0020 r attending physic use as the burial		1 Never Merried 2 Merried	FORCES? 1 YES			specify Cuben, Mexic (ES 2 X NO Specific			Black, White, etc. Specify:			
ending as the	ВУ	3 Widowed 4 Divorced					,	A	frican American			
or attending or use as the	ED	15. DECEDENT'S EDU (Specify only highest grade	CATION COMMISSION	16a. DECEDE	NT'S USUAL OCCUPY d of work done during	ATION	16b. KIND OF E	USINESS/INDU				
0 -		Elementary/Secondary (0-12)	College (1-4 or 5+)	IIIe. Do N	Of use retired.)	most or working						
	COMPLI	12th grade			r		Accou	stical/T	iling Co.			
AND he hospit detached once.	ő	17. FATHER'S NAME (First, Middle, Last)				18, MOTHER'S NA	ME (First, Middle, Meid	an Surnamel				
# 8 A	S I	Stevenson Spence,	Sr.				die Briddel					
tained should	00	19e. INFORMANT'S NAME (Type/Print)		10h MAI	I INO ADDRESS (Com							
ay be repage 5	임	Mrs. Blondie Spence			e as abov		Route Number, City or 1	own, Stete, Zip C	ode)			
		20e. METHOD OF DISPOSITION										
		1 De Burial 2 Cremation 3 Rem		b. PLACE AND D metery, cremator	ATE OF DISPOSITION or other place)	(Name of			ty or Town, State			
ALTIMOF Jeath. Page 6 m funeral director, xaminer must		4 Donation 5 Other (Specify)	E		n Cemete		10/11 Be	rlin, Mo	aryland			
ALTIN death. Pag funeral dii f. examiner	1	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND AODRESS OF FACILITY Jolley Memorial Chapels										
AL fun fun		1213 Jersey Road - Salisbury, MD 21801										
hours after death. ed in by the funera or removal. medical examil		23 BATT I Feler the disease or some										
nours afte d in by th or remov		ahock, or heart failure. List only one cause on each line. Approximate interval Between										
r filled to the m		IMMEDIATE CAUSE (Final Onset and Death										
E 5 8 5		disease or condition										
		OUE TO (OR AS A CONSEQUENCE OF):										
becuted and con burial,	z	Sequentially list conditions, If any, leading to immediate Due TO (OR AS A CONSEQUENCE OF): Peripheral Vascular Disease 2lyrs.										
	ERTIFICATION											
ate be prior prior	3	CAUSE Dieses or blury										
. g d e	E	that initiated events DUE TO (OR AS A CONSEQUENCE OF):										
eath cert attending mal Hygie Y, or ot	E	d. Hypertensive Cardiovascular Disease										
he death the atte Mental	2											
= 20 =	A	PART ii. Other significant condition			ing in the underly	ing cause given in	Part I. 24a. WAS /	N AUTOPSY	24b. WERE AUTOPSY FINDINGS			
any and b	EDICAL	Anemia,			1 □ YES X □		AMAILABLE PRIOR TO COMPLETION OF CAUSE					
S te ge E							_		OF DEATH?			
w required show	Σ.	DID TORACCO LISE CONTI	PIRLITE TO CALISE O	DE DEATH	VES [] NO	T UNICEDTA!			1 YES 2 NO			
2 6 88 e	A I	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)										
N: The icate be State	SICIAN:	EXAMINER?	HOSPITAL:		OTHER:							
SICIAN: The Certificate of the State	1×S	1 NES 2 NO	1 Inpatient 2 ER/Out			ome 5 Residence						
this of the control o	РНҮ	27. MANNER OF DEATH 1 🔀 Netural 5 🗍 Pending	(Month, Day, Year)	28b.	TIME OF 28c. I	NJURY AT WORK?	28d. OEŞCRIBE HOW	INJURY OCCU	RED			
After the death of mark	Æ	2 Accident Investigation				YES 2 NO						
S G A A	9	3 Suicide 6 Could not be	28e. PLACE OF INJUR building, etc. (Spe	Y — At home, fa	rm, street, fectory, of	flice 281. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
ATTEN ATTEN ECTOR: s after		4 Homicide determined						-,				
DIRE	COMPLET	290. CERTIFIER 1 TO CERTIFYING PHYSI	CIAN: To the best of my know	viedos death oc	curred at the time d	te and place, and due	to the cause(s) and m					
로 장 전 ==	Ž	CERTIFFIER (Check only one) 1 CERTIFFIER (Check only one) 2 MEDICAL EXAMINER: On the base of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(e) end menner ee stated.										
HOSP TUNE VITHIN	8				garon, in my opinion	, death occured at the	time, date end piace,	and due to the o	cause(e) end manner ee stated.			
THE HOSPITAL THE FUNERAL filed within 72 PORTANT: If	88	29b. SIGNATURE AND TITLE OF CERTIFIER	16	10		29c. LICENSE NUI	MBER	29d. DATE S	SIGNED (Month, Day, Year)			
- C C	100	Van Sh	MUZ.	トレ		D1600)3	14	15/95			
2 2 2 3				30. NAME AND ADDRESS OF PERSON WHO COMPLETED USE OF DEATH (ITEM 27) (Type, Print)								
F	2											
±						ISBURY.	MD. 218	02-201	8			
\ F		30. NAME AND ADDRESS OF PERSON WH I.J. HWANG, M. 31. DATE FILED (Month, Dey, Year)	D., P.O. I	3OX 20	18, SAL	ISBURY,	MD. 218	02-201	L8			
+ + 5 €		I.J. HWANG, M.	D., P.O. I	3OX 20	18, SAL	ISBURY,	MD. 218	02-201	.8			

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BALTIMORE, MARYLAND 21215-0020

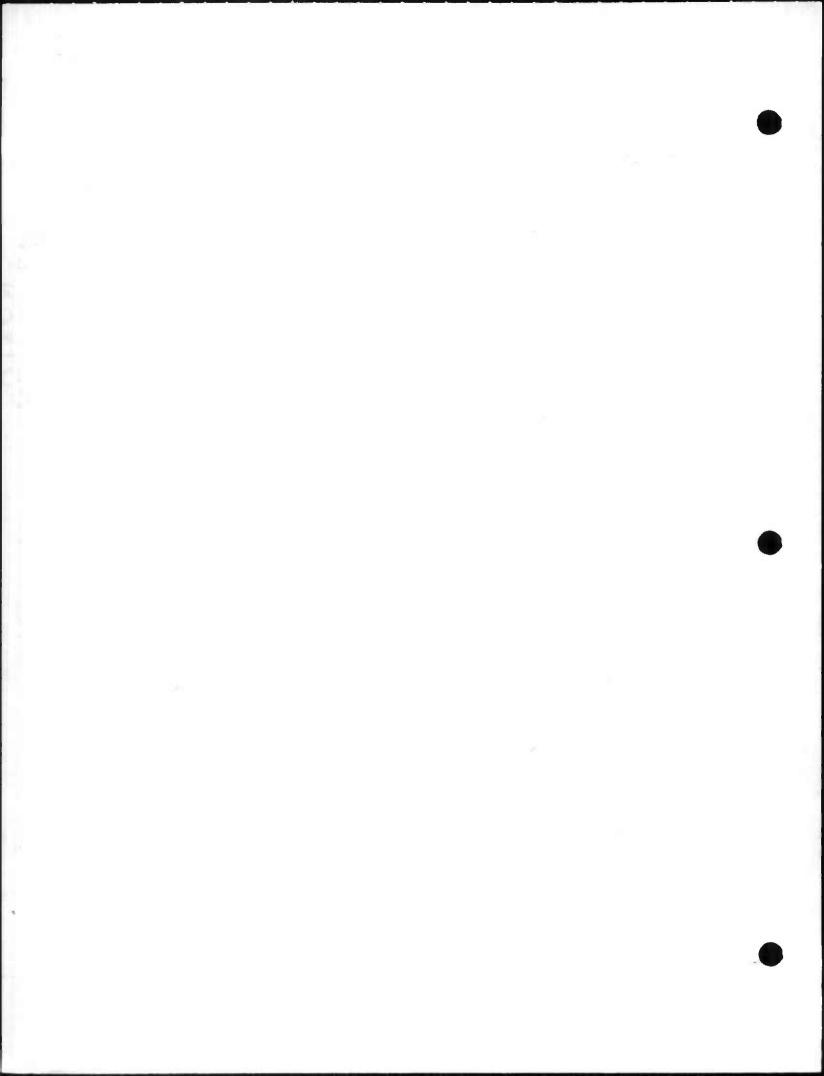
DIVISION OF VITAL RECORDS, P.O. BOX 68760

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Through the same and the same a
IMPUBLIANT: IT ITEM 28 IS MARKED, OF NEM 23 SHOWS ANY INJURY, OF OTHER TRAINMENT (FOR MEDICAL EXAMINER MUST BE ROLLIFED AT ORCE.

FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR CERTIFICATE OF DEATH REG. NO.										
	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF DEATH 3. TIM				
	Preston Albe	rt			TH	MONTH	DAY	YEAR) , 9 % 1 -			
	4. SOCIAL SECURITY NUMBER		E (In yrs. lest birthday)	IF UNDER 1 YEAR		7. DATE OF	EN 10	-	8/41- M		
	214-30-9045	1xxM 2 □ F	58 YRS.	WONTHS DAYS		(Month, De		Cour	THPLACE (State or Foreign stry) Tyland		
	9s. FACILITY NAME (If not institution, give s	street and number)	-	9b. CITY, TOW	OR LOCATION OF D			c. COUNTY OF			
DIRECTOR	PENINSULA REGI	ONAL MEDICA	L CENTER		SALISBURY			WICOMICO			
<u>[</u>	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT	v	I so or	Y, TOWN OR LOC							
E		/orcester		erlin	ATION				10d. INSIDE CITY LIMITS?		
	100. STREET AND NUMBER	orcester						1 YES 2 NO			
FUNERAL	10522 Harrison Ro	ad			21811		10	USA	WHAT COUNTRY?		
N S	11. MARITAL STATUS	12. WAS DECEDENT EVER	IN U.S. ARMED	S. ARMED 13. WAS DECENDENT OF HIS			necity Yea or		CE — American Indien,		
BY F	1 Never Merried 2 Married 3 Widowed 4 Divorced	S 2 NO DATES	If yes,	specify Cuban, Mexica ES 2X NO Specif	Ify Cuban, Mexican, Puerto Rican, etc.) NO Specify:			ck, White, etc.			
8	15. DECEDENT'S EDUCATION 166. DECEDENT'S USUAL OCCUPATION 186. KIND OF BUSINESS/INDUSTRY										
	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind of a	work done during .							
COMPLET			Bus Cont	Bus Contractor			Worcester County Bd. of B				
Ö	17. FATHER'S NAME (First, Middle, Last)										
BE	Robinson Britting	ham, Sr.			Anna S	mith					
0	19a. INFORMANT'S NAME (Type/Print)		19b. MAILINO	AODRESS (Street	t and Number or Rural	Route Number, (City or Town, S	tate, Zip Code)			
F	Mrs. Marion N. Smi	ith	same as above								
1	20e. METHOD OF DISPOSITION 1 [6] Burlel 2 Cremetion 3 Rem	loval from State	0b. PLACE AND DATE (OF DISPOSITION	Name of	DATE	20c. LOCAT	ION — City or 1	ity or Town, State		
1	4 Donation 5 Other (Specify)	C	emetery, crematory or of alvary Ch			10/14	Berli	n, Mary	aryland		
	21. SIGNATURE OF FUNERAL SERVICE LIC	CENSEE		22. NAME	AND ADDRESS OF FA	Joll	ev Me	morial	Chapel		
	MACRICIA	10 SHI	OU.	1213	Jersev Ro						
	23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or reaplratory arrest, Approximate										
1	ahock, or heart failure. List only the cause on each line. IMMEDIATE CAUSE (Final										
	disease or condition resulting in death)	Cara	line o	00106					30 + min		
H	DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): AT PROSCUENTIAL CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):										
z	Constraint the true of all true	a ATheros	clerotas	Ca	dioras	cular	di	alust	5unni		
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS	A CONSEQUENCE OF	7:					go		
할	cause. Enter UNDERLYING CAUSE (Disease or injury	C									
	that initiated eventa resulting in death) LAST	DUE TO (OR AS	A CONSEQUENCE OF	7:							
崽	6.										
	PART ii. Other aignificant condition	a contributing to death	but not reaulting i	n the underly	ng cause given in	Part i. 24s	. WAS AN AUT		b. WERE AUTOPSY FINDINGS		
DICAL	Suberdocardial myorardial infanction 1 PERFORMED?							AVAILABLE PRIOR TO COMPLETION OF CAUSE			
MEC	Déabetes	mille	Tun-	1			120		OF DEATH?		
	DID TOBACCO USE CONT			S 🗆 NO	UNCERTAIL	νП					
X	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEAT								
PHYSICIAN:	EXAMINER?	HOSPITAL:	itpatient 3 🗆 DOA	OTHER: 4 Nursing Ho	me 5 🗆 Residence	6 Other (So	ecify)				
	27. MANNER OF DEATH	26a. DATE OF INJURY (Month, Day, Year)		E OF 28c, II	NJURY AT			RY OCCURED			
ВУ	1 Natural 5 Pending 2 Accident Investigation	(WOILL, Day, real)	JNS		YORK? YES 2 NO						
	3 Suicide 6 Could not be	28a. PLACE OF INJUR building, etc. (Sp	RY — At home, farm, a	treet, factory, of	lca	28f. LOCATIO	N (Street and i	Number or Rural	Route Number,		
2	4 Homicide determined		33.177			City or io	wn, siele)				
2	29a. CERTIFIER (Check only CERTIFYINO PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) end menner as stated.										
COMPLETED	one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner as stated.										
U U	296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)										
-	May Can I	Maal-	m.p.		D192	89			10/00		
욘	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUSE OF		Print)	10.,4	,		10/	10/13		
	Po Box 2	636 Sal	is burns	mo	2180	/					
	31. DATE FILED (Month, Day, Year)	32 REGISTRAR'S SIG	NATURE 1								
	OCT 13 1995	Julia dande	DE NAME AND								
		·									



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the new feath. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral directio, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

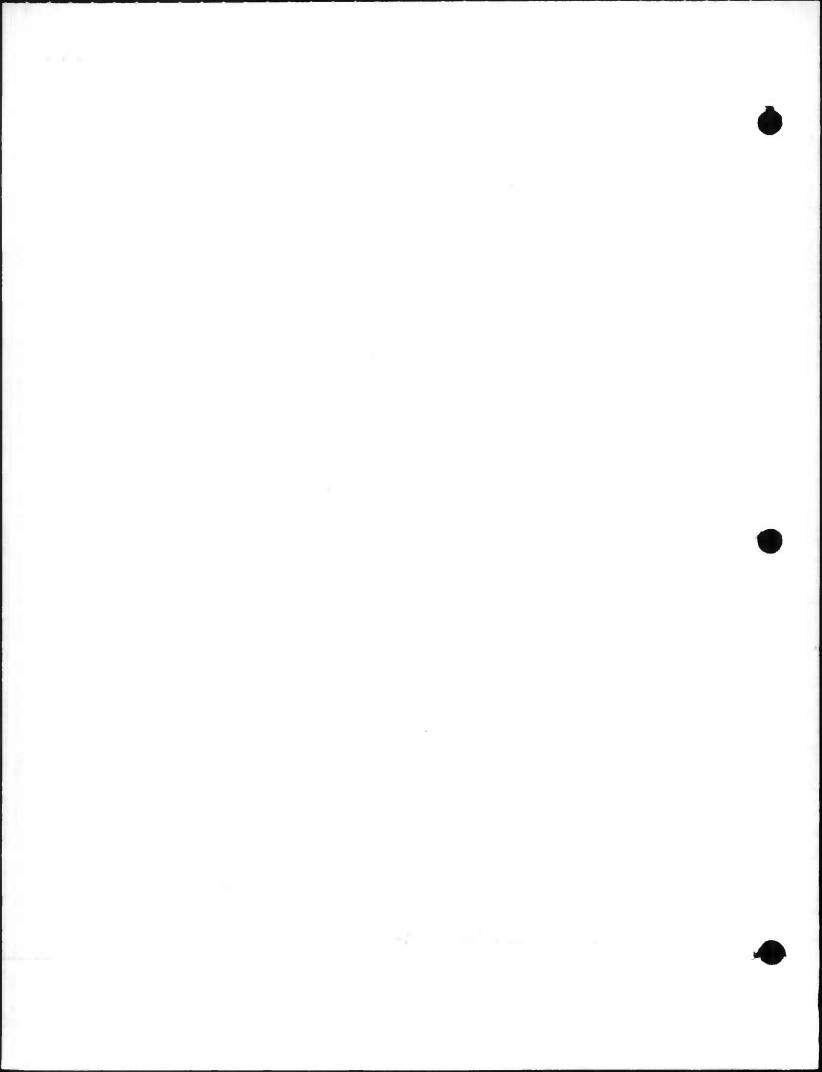
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

	REGISTRAR		CERTIF	ICALE	JE DEATH	REG. NO					
	1. DECEDENT'S NAME (First, MICHOLE, Lest) FLORENCE VIRGINIA SMITH (Smith) 2. DATE OF DEATH MONTH DAY VEAR Q 3. 198 2. 3. TIME OF DEATH OCTOBER 3. 198 2. 3. TIME OF DEATH								3. TIME OF DEATH		
	4. SOCIAL SECURITY NUMBER 222-10-0074 5. S	6. AGE	(In yrs. last birthday) YRS.	IF UNDER 1 YE		7. DATE OF BIRTH (Mogth, Day, Year)	- 1	8. BIRTHPLACE (State or Forei Country)			
	9a. FACILITY NAME (If not institution, give atreet a		nivern.		WN OR LOCATION OF D	1/	9c. COUNTY OF DEATH				
OT	PENINSULA REGIONAL RESIDENCE OF DECEDENT	MEDICAL C	ENTER	CR SALISBURY WICOMI							
DIRECTOR	DELAWARE SUSSEX		10c. CIT	10c. CITY, TOWN OR LOCATION GEORGETOWN				10d. INSIDE CITY LIMITS? 1 YES XX NO			
BY FUNERAL	RD 3 BOX 395				7 IOg. CITIZEN OF WNAT			NAT COUNTRY?			
	· Charles · Martin	WAS DECEDENT EVER FORCES? 1 1 YES F YES, GIVE WAR OR I	2 100	INO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify William) 14 yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 NO Specify:			ps or No				
TED	15. DECEDENT'S EDUCATIO (Specify only highest grade comp		16s. DECEDENT'S	work done durin	PATION g most of working	16b. KIND OF BU	SINESS/INDU	STRY			
PLE	Elementary/Secondary (0-12) Coffege (1-4 or 5+)			HONEMAKER			HOME				
BE COMPLETED	17. FATHER'S NAME (First, Middle, Last) JOHN E. MARTIN				18. MOTHER'S N	AME (First, Middle Maiden D WAPLES	Surname)				
TO B	190. INFORMANT'S NAME (Type/Print) NOAH B. SMITH		196, MAILING	BOX 3	95 GEORGE	TOWN, DE TO	n, Steip, Zip 0	Code)			
	20 METHOD OF DISPOSITION 1/ Burlel 2 Cremation 3 Removal 1 4 Donation 5 Other (Specify)	rom Stata 20			DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State 10—3 MILTON, DE						
	21. SIGNATURE OF FUNERAL SERVICE LICENSE Selly Sepole	E	C)COT CIT	23 HO	RT FUNERAL	SERVICES VILTON, DE	INC				
	23. PART I. Ental the diseases, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory arreat, interval Batween Onset and Death disease or condition resulting in death) Approximate interval Batween Onset and Death Conset and Deat										
CERTIFICATION	0.000								10 yrs		
- 11	PART II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24s. WAS AN AUTOPSY FINDINGS PERFORMED? AMILIABLE PRIOR TO										
EDICAL	CORONARY AR		AJE,	Ε,			N NO		AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
Σ	DIABETES MELLITIS DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN										
PHYSICIAN	25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)										
YSIC	1 TYES 2 NO 1	9PITAL: Inpetient 2 ☐ ER/Out	petient 3 DOA	OTHER: 4 Nursing	Home 5 - Rasidenca	8 Other (Specify)					
ВУ РН	27. MANNER OF DEATH 1 M Netural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	LNI	28b. TIME OF UNJURY AT WORK? M 1 YES 2 NO 28d. DE\$CRIBE HOW				INJURY OCCURED			
	3 Suicide 8 Could not be detarmined	28a, PLACE OF INJUR building, etc. (Spe	f — At home, term, s cify)	me, tarm, street, factory, office 281. LOCATION (S City or Town,			(Street and Number or Rural Route Number, n, State)				
COMPLETED	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as started. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as started.										
TO BE	29c. LICENSE NUMBER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) D42522 10 4 95										
	30. NAME AND ADDRESS OF PERSON WHO CON	mn &	14-D &	Print) Carle	in shore	Drive, P	alir	lyg	mp 21801		
	31. DATE FILED OCT 12 1995	32. HEGISTRAP'S SHE	IATURED LANGER					U			



		FOR STATE REGISTRAR	STAT	E OF MARYL	AND / DEPAI CERTIF	RTMENT OF I	HEALTH AND	MENTAL HYGIE		00		
		1. DECEDENT'S NAME (First, Mid	Idle, Last)	Davil /				2. DATE OF DEATH	DAY	3.	TIME OF DEATH	
)		MARY HON	JARY AGNES SMITH							3	0207 M	
		4. SOCIAL SECURITY NUMBER 149-48-6	668 1 M	orda .	(In yrs. lest birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIFTH (Month, Day, Year) April 9		Country)	CE (State or Foreign	
3 should		9a. FACILITY NAME (If not institut	tion, give street and n			9b. CITY, TOWN	OR LOCATION OF D	1-1-11	9c. COUNT		н	
2	DIRECTOR	Anne Arundel Med. Ctr. Annapolis Anne Arundel										
L. Pages	DIRE		nne Arı	ındel		nold	TION				I. INSIDE CITY LIMITS? YES 2 XNO	
pemi	AL A	104. STREET AND NUMBER					f. ZIP CODE		10g. CITIZE		COUNTRY?	
n. ansit	FUNERAL	519 Augusta	Dr.				21012		IISA			
fing physician. the bunal-transit permit. Pages 1.	BY FUI	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	ried FOR	DECEDENT EVER II CES? 1 YES ES, GIVE WAR OR D	2 X NO	13. WAS DEC		14. RACE — American Indian, Black, White, etc. Specify:				
r attend use as	G		NT'S EDUCATION heat grade completed	2	16a. DECEDENT'S	USUAL OCCUPATION	ON	16b. KIND OF B	USINESS/INDUS		hite	
the hospital or attending detached for use as the once.	OMPLET	Elementary/Secondary (0-12)		(1-4 or 5 +)	lite. Do NOT u	work done during mo se retired.)	ost of working					
the hospital o detached for once.	MP	1 Homemaker Home										
be detach	0	17. FATHER'S NAME (First, Middle,		-				AME (First, Middle, Maide	_			
	8	John 19a, INFORMANT'S NAME (Type/F	McDor	nnell			Lilli		Carey			
retained 5 should notified	임	Francis R.						Route Number, City or To		ode)		
page page		20a. METHOD OF DISPOSITION		206	519 PLACE AND DATE			nold MD	OCATION - CIT	v or Town	State	
age 6 ma director, p er must		ty☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 6 ☐ Other (Spe		Stata cen	netery, crematory or c D. Veter	ther plece)			ownsv			
. Pag ral dir	1	21. SIGNATURE OF FUNERAL SE	BYACE LICENSEE		D. VELET		NO ADDRESS OF FA		OWIISV	TILE	, MD	
death. Pag tuneral dii I. examiner		1621	1120	11				Sons FH		itch	ie Hwy	
24 hours after filled in by the tion, or removal the medical		23. PARY I. Enter the disease	sea, or complica	liona thei caused	d the death. Do	Seve	rna PAr	k MD 21	146	t I	Approximats	
		ahock, or heart feliure. List only one ceuse on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) Due To (OR AS A CONSEQUENCE OF):										
8 6 4 6	_	Sequentially list conditions. 6. EARDIOGENIC STOCK 8										
	CERTIFICATION	If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):										
	CA	cause, Enter UNDERLYING CAUSE (Disease or injury	2 . A	cute r	Myocar	dial	ļ	8				
Sertifical ling phy ygiene i other	F	that initiated svents resulting in death) LAST	1	DUE TO (OR AS A	CONSEQUENCE O	F):	0					
he death certifi the attending p Mental Hygien Ijury, or oth	CER		d									
라 다 아 를	7	PART II. Other significent c	onditions contrib	outing to death b	out not resulting	in the underlying	g ceuse given in			01.00	RE AUTOPSY FINDINGS	
tuires that the signed by the Health and DWS any In	MEDIC							1 _ YES	PRMED?	COI	ALABLE PRIOR TO APLETION OF CAUSE DEATH?	
requires een sign of Heal	ME										YES 2 NO	
e faw requents been Dept. of 1 23 sho	ä	DID TOBACCO USE		TO CAUSE O			UNCERTAI	NX				
N: The icate h State I	SICIAN:	25. WAS CASE REFERRED TO ME EXAMINER?	HOSPI	ITAL:	26. PLACE OF DEA	OTHER:						
SICIAN: The certificate the State I, or item	PHYS	1 YES 2 NHO 27. MANNER OF DEATH		tilent 2X ER/Outp		4 - Nursing Hom		6 Other (Specify)				
this with	BY P	1 Netural 5 Pend		(Month, Day, Year)	26b. TIM	URY WO	YES 2 NO	28d. DESCRIBE HOW	INJURY OCCUR	RED		
NDING R: After r death		3 Suicide 6 Could	28a	PLACE OF INJURY building, atc. (Spec	— At home, tarm,	street, factory, offic		261. LOCATION (Street	and Number or	Rural Route	Number,	
OR ATTENDING DIRECTOR: After hours after death Item 28 is ma	ETED	4 Homicide dater	mined	Donaing, atc. (Spec	,ay)			City or Town, State	9)			
L DIRECT Pours	PLE	29a. CERTIFIER (Check only	NG PHYSICIAN: To II	he best of my know	ledge, death occurr	ed at the time, data	and place, and dus	to the cause(s) and mi	nner as stated.			
HOSPITAL FUNERAL WITHIN 72 N	COMPL							time, data and place, a		ause(s) and	manner as stated.	
THE HOSPITAL THE FUNERAL filed within 72 I	w II	29b. SIGNATURE AND TITLE OF	CERTIFIER				29c. LICENSE NUI	MBER	29d. DATE SI	IGNED (Mor	nth, Day, Year)	
5 5 3 A	0 8	Karbana	L. Bean				D3940	17	10.	-22	-95-	
		Barbara L.					Annan	olie MD	21/0	1		
		31. DATE PILED (MORRI, Day, Year)	32.1	REGISTRAR'S SIGN	ATURE	Ru	mnap	OLIS, MD	2140	1		
		OCT 261	995	develop	Reveall							

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the funeral direction, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should

_	FOR STATE	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL	HYGIENE
_	REGISTRAR	CERTIFICATE OF DEATH	REG. NO.

		1 - STATE REGISTRAR		SIAIE UF I	MANTLA	CEF	RTIF	CATI	E OF	DEA	TH	MENTAL HYGIEN REG. NO	_		
	;	1. DECEDENT'S NAME (First, ERNEST CLI	FFORD	STROBEI								2. DATE OF DEATH BOCTOBER 2	8, 19	995	3. TIME OF DEATH 12:05 A M
		4. SOCIAL SECURITY NUMB		5. SEX	111.	In yrs. last bir	rthday)	IF UNDER	1 YEAR	IF UNDER	MIN.	7. DATE OF BIRTH (Month, Day, Year)	1918	8. BIRTHP Country)	YORK
S S		90. FACILITY NAME (If not in: CUPPETT-WEE			ſE				, town	OR LOCATI	ON OF DE		9c. COU	INTY OF OE	
DIRECTOR		RESIDENCE OF DEC	10b. COUNT	γ		-1	loc. CITY	, TOWN	OR LOCA	TION					10d. INSIDE CITY
		MARYLAND 100. STREET AND NUMBER	GAR	RETT			M	CHE		H. ZIP COD	E		10a CIT		LIMITS? 1 YES 2 NO HAT COUNTRY?
FUNERAL		7216 SANG R	RUN ROA		T 51100 111		21541							USA	
¥		1 Never Merried 2 💢 3 Widowed 4 Divor		FORCES? 1	1 X YES 2 NO If yes, specify Cuben,				m, Mexicer	HISPANIC ORIGIN? (Specify Yes or No— , Mexicen, Puerto Ricen, atc.) Specify:			WHITE		
COMPLETED		15. DECI (Specify only Elementery/Secondary (0- 12	·)	16a. DECED (Give I life. Do PLAN	NOT use	ork done retired.)	during m	ost of workli	ng	OPTIC			ANUFACTURE		
TO BE COM		17. FATHER'S NAME (First, Middle, Last) PAUL P. STROBEL 18. MOTHER'S NAME (First, Middle, Meiden Surreme) CORA M. SICK													
TO I		ALICE STROB								and Number N ROA		McHENRY,			21541
must b	20e. METHOD OF DISPOSITION 1 M Burlet 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of complete complete), commander of complete comple														
medical examiner must		22. NAME AND ADDRESS OF FACILITY P.O. BOX 243 DURST FUNERAL HOME - OAKLAND, MD 21550													
r other traumatic event, the RTIFICATION		23. PART I. Enter the diseases, or complications that caused the desth. Do not enter the mode of dying, such as cardisc or respiratory arrest, above, or heart failure. List only one cause on asch line. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. atherosclerotic cardiovascular disease DUE TO (OR AS A CONSEQUENCE OF): b. OUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): OUE TO (OR AS A CONSEQUENCE OF): OUE TO (OR AS A CONSEQUENCE OF):													
Injury.	,	PART II. Other algolficer							derlyin	g ceuse (given in i	Part I. 24s. WAS AN			WERE AUTOPSY FINDINGS
MED MED		diabetes me										1 YES 2			COMPLETION OF CAUSE DF GEATH?
Item 23 sl		DID TOBACCO US 25. WAS CASE REFERRED TO EXAMINER?		HOSPITAL:		F DEATH	F OEAT	4 (Check	only one)	UNC	ERTAIN				
ked, or I			Pending	1 Inpatient 2 I	INJURY	-	Bb. TIME	OF	26c, INJ WC	IURY AT DRK?		Other (Specify) 28d, OE\$CRIBE HOW I	NJURY OC	CURED	
28 Is TED		3 Suicide 6 0	could not be letermined	26e. PLACE O building,	F INJURY . etc. (Specif	— At home,	term, at	raet, tact			, 100	28t. LOCATION (Street of City or Town, State)	and Number	r or Rural Ro	ute Number,
ANT: If item												to the cause(s) and mar lime, date end place, en			and manner ee stated.
IMPORTANT: TO BE COM		295. SIGNATURE AND TITLE 30. NAME AND ADDRESS OF	Then	man.		MD:	7) (Type,	Print)		29c. LICE D257	7 5 9	BER			Month, Day, Year) 28, 1995
	-	Walter K. Na	umann	, M.D., P	О Во	x 247	, A	cci	lent	MD 2	21520)			
		31. DATE FILEO (Month, Day,)	0 199	32. 9 GISTRA	EUCLA EUCLA	orker	4								

24 hours after death. Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020

Pages 1, 2, 3 should

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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 1995 October 20, 6:15 Richard Winfield Selby, Jr. DM 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (in yrs. lest birthday) 7. DATE OF BIRTH (Month, Day, Year July 2, 8. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. 1 X M 2 F 579 - 52 - 9238 1943 Washington, DC Sa. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Golden Oaks Nursing Home Laurel Prince George 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Prince George Maryland 1 TY YES 2 NO Laurel FUNERAL 10a. STREET AND NUMBER 101. ZIP CODE 10n, CITIZEN OF WHAT COUNTRY? #203 20707 203 Stanley Place USA 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-if yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. RACE --- American Indian, Black, White, etc. FORCES? 1 YES 2 2 X NO 1 Never Married 2 Married 1 YES 2 NO Specify: Specify: BY 3 Widowed 4 Divorced White 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16h KIND OF BUSINESS/INDUSTRY (Specify only highest grade completed) ET Flementary/Secondary (0-12) College (1-4 or 5 +) COMPL Metal Fabrication Grade 8 Metal Lather 17. FATHER'S NAME (First Middle Lest) 16. MOTHER'S NAME (First, Middle, Maiden Surname) Richard Winfield Selby, Sr. Marjorie Joan Barron 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Kathleen Jones Yost 2119 5th Street, Owings, Maryland 20736 20a. METHOD OF DISPOSITION 20c. LOCATION - City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20s. METHOD OF DISPOSITION

1 Burial 2 Cremation 3 Ramoval from State

4 Donation 6 Other (Specify) Metro Crematory, Inc. 10/25 Catonsville, Maryland 21. SIGNATURE OF FURERAL SERVICE LICENSES 22. NAME AND ADDRESS OF FACILITY Donaldson Funeral Home, P.A. ill 313 Talbott Ave. Laurel, Maryland 23. PART I. Enter the displace or complications that caused the death. Do not enter the mode of dying, such as cardiac or reaptratory arrest, shock, or heart salure. Liet only one ceuse on each line. 20707 interval Between Onset and Death IMMEDIATE CAUSE (Final disease or condition Metastatic Lung Cancer Months reaulting in death) DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF) thet initiated eventa reaulting in death) LAST PART II. Other aignificent conditions contributing to deeth but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS MEDICAL AMILABLE PRIOR TO COMPLETION OF CAUSE 1 TYES 2 XNO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☒ NO ☐ UNCERTAIN ☐ PHYSICIAN: 26. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL HOSPITAL: OTHER: 1 YES 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 4 M Nursing Homa 5 - Residence 6 - Other (Specify) 27. MANNER OF DEATH 28d. DESCRIBE HOW INJURY OCCURED 28s. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 1 (X) Natural 5 Pending 1 YES 2 NO BY Investigation 2 Accident 3 Suicide 26a. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined COMPLETED 4 Homicide 29a. CERTIFIER (Check only (Ch 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month. Day, Year BE Mon an D43260 October 21,1995 0 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 14333 Laurel Bowie Road #307, Laurel, Maryland 20708 Jenny Y. Moy, M.D.

32 MEDISTHAN'S SIGNATURE Jalia Davilson Raydall

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with. The hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlal-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlal, or removal.

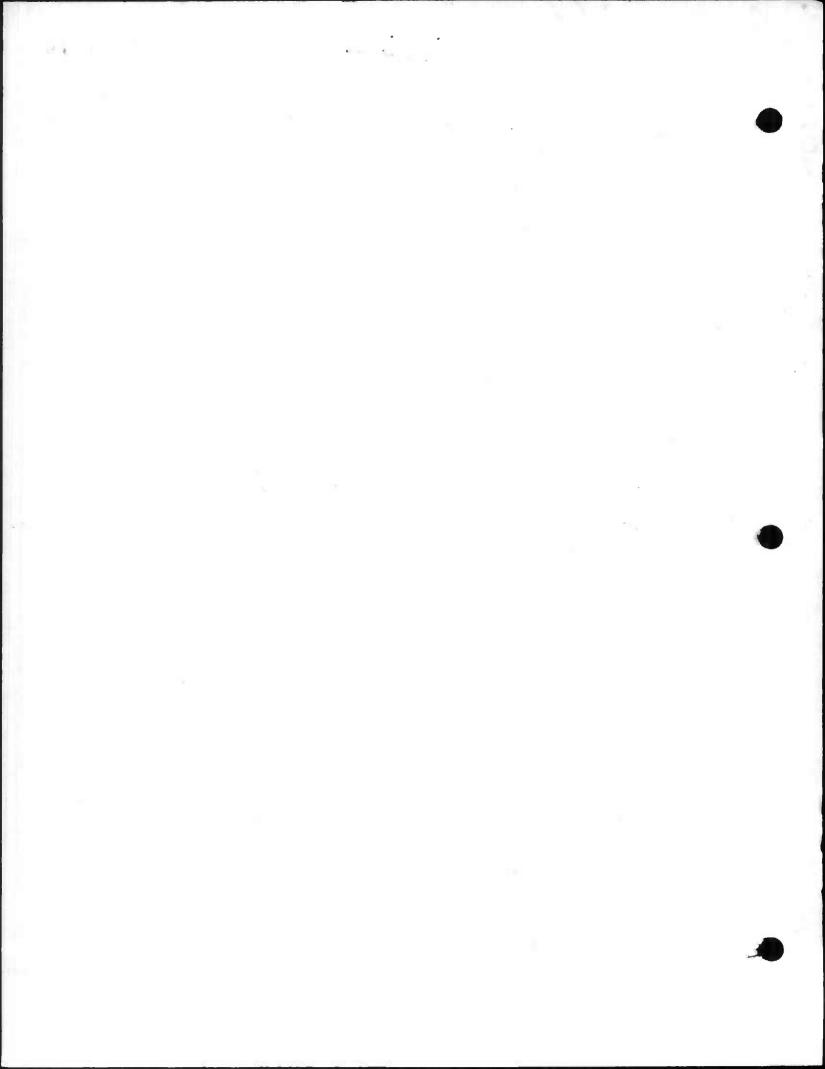
IMPORTANT: It Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

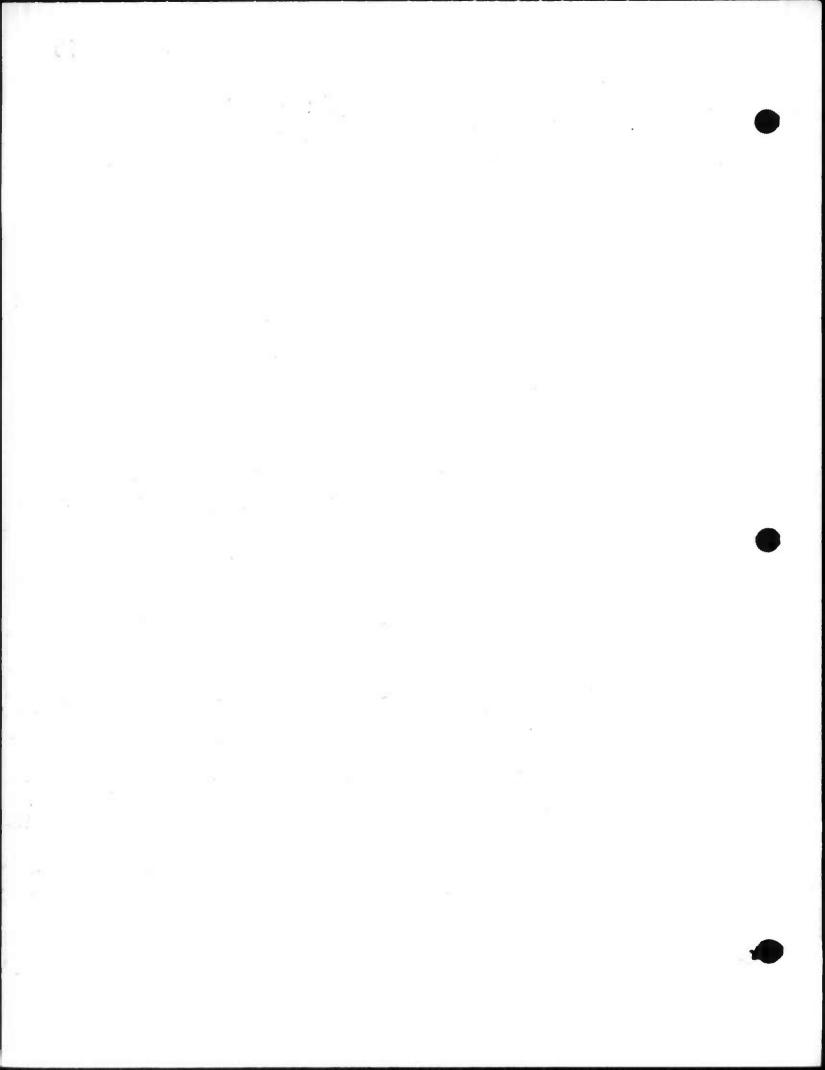
E STRAR	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL CERTIFICATE OF DEATH	HYGIENE REG. NO.
UT'O MARK (First Address 1 4)		

	FOR STATE REGISTRAR	STATE OF MARY	LAND / DEPAR CERTIF					MENTAL HYGIEI			
	1. DECEDENT'S NAME (First, Middle, Las	John	SOMMERWERCK			r		2. DATE OF DEATH	77 K	YEAR	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER 212-09-2304	1 🔀 M 2 🗆 F	E (In yrs. last birthday) 79 YRS.	IF UNDER		IF UNDER	1 24 HRS. MIN.	7. DATE OF BIRTH (Month, Day, Year) Dec. 29,		Country	PLACE (State or Foreign
OR	90. FACILITY NAME (If not institution, give	Street and number) HO	spital	9b. CITY		R LOCATI	ON OF DE		9c, COUN	_	ATH
DIRECTOR		10a. STATE 10b. COUNTY									10d. INSIDE CITY LIMITS?
	10e. STREET AND NUMBER	TALL TOLK			el A	ZIP CODI	E		10g, CITIZ		1 YES 2 NO
FUNERAL	1500 Dundee Ct	•				2	1014			USA	
BY	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	IN U.S. ARMED B 2 NO DATES CA		If yes, sp	cify Cube	OF HISPAN In, Mexicar Specify	IC ORIGIN? (Specify Yen, Puerto Rican, etc.)	s or No-	14. RACE Black, Specify	- American Indian, White, etc.	
COMPLETED	15. DECEDENT'S EI (Specify only highest gra Elementary/Secondary (0-12)	DUCATION ide completed) College (1-4 or 5+)	16a. DECEDENT'S (Give kind of life. Do NOT us	USUAL Of work done of retired.)	CCUPATIO during mo	IN st of workin	ng	16b. KIND OF BU	ufact		
MP		4	Cred	it M	anag						9
	17. FATHER'S NAME (First, Middle, Last) Daniel Rudolph	Sommerwerck						WE (First, Middle, Melder			
BE	190. INFORMANT'S NAME (Type/Print)	SAMETWELCK	19b. MAILING	ADDRESS	S (Street a			ca Julia loute Number, City or Tox			
임	Elizabeth T. Som	merwerck								,	
20a. METHOD OF DISPOSITION 1 Burlal 2 Commetton 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of cametary, crematory or other place) 20c. LOCATION — City or Town, Blate											
	22. NAME AND ADDRESS OF FACILITY HOWARD K. McComas III Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, Md. 21009										
2	23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feliure. List only one cause on each line. IMMEDIATE CAUSE (Final diseases or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): Arthropy Canadial Tryphochemics (Interval Between Onset and Death Onset and Dea										
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): C. DUE TO (OR AS A CONSEQUENCE OF):										
MEDICAL	PART II. Other significant condition						given in I	Part I. 24a. WAS AP PERFO 1 TYES	RMED?	1	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
HYSICIAN:	DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	11/2	26. PLACE OF DEAT			UNC	ERTAIN				
2	1 YES 2 NO	HOSPITAL: 1 Inpatient 2 ER/Ou	tpatient 3 DOA	OTHER		5 🗆 Re	sidence (B Other (Specify)			
ВУ РН	27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	28e. DATE OF INJURY (Month, Dey, Year)		E OF URY M	28c. INJUNO	JRY AT RK? ES 2] NO	28d. DESCRIBE HOW	INJURY OCCU	RED	
9	3 Suicide 6 Could pet b	28e. PLACE OF INJUR building, etc. (Sp	IY — At home, ferm, secify)	treet, facto	ory, office			281. LOCATION (Street City or Town, State	end Number o	r Rural Ro	ute Number,
COMPLE		SICIAN: To the best of my kno									and menner se stated
4	296 SIGNATURE AND TITLE OF CERTIF					NSE NUM				Month, Dey, Year)	
2	30. NAME AND ADDRESS OF PENSON W	HO COMPLETED CAUSE OF O		Print	200	2 0	1160	ow pre	FOLY	TOW	mo 21047
	31. DATE FILED (Month, Day, Year)	AZ REGISTRARIS SIG	MAD.	18	FCC	معل ا	~	GEW ENA	r ff	JA	1066
	OCT 26 1995 Julia Muslean Kardall										



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		1 - FOR STATE REGISTRAR	STATE OF MARYL		RTMENT OF		MENTAL HYGIEN							
	1	1. DECEDENT'S NAME (First, Middle, Last) ALISON	CDOCKED		GANDEDG		2. DATE OF DEATH MONTH D	AY YEAR	3. TIME OF DEATH					
			CROCKER 5. SEX 6. AGE	(In yrs. last birthday	SANDERS	IF UNDER 24 HRS.	OCTOBER 1		5:05 P M					
20		219-29-7771	1 - M 2 X F 7		MONTHS DAYS		July 27, 19	Coun						
3 should	<u>~</u>	9e. FACILITY NAME (If not institution, give street				N OR LOCATION OF D	EATH	9c, COUNTY OF						
ci.	CTOR	THE JOHNS HOPKIN	S HOSPITAL		BALTI	MORE CITY	<u> </u>	None						
Pages	DIRE	Maryland Montq	OMOTIV		TY, TOWN OR LOC				10d. INSIDE CITY LIMITS?					
Dermit.		Maryland Montg 100. STREET AND NUMBER	Olliet À	3	ilver Sp	101. ZIP CODE		10g. CITIZEN OF	1 YES 2 NO					
an. ransit	FUNERAL	10002 Rogart Road				20901		United	States					
hospital or attending physician. ached for use as the burial-transit permit. Pages 1,	B	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	2. WAS DECEDENT EVER II FORCES? 1 1 YES IF YES, GIVE WAR OR D	2 K NO										
	PLETED	16. DECEDENT'S EDUCATION only highest grade continued to the continued to	FION mpleted) College (1-4 or 5 +)	16a. DECEDENT (Give kind o life. Do NOT Studen		School	White							
det det	COMPLI	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	AME (First, Middle, Maiden							
5 % To	BE	Robert C	•		ders	Elizat			Knox					
F 55	임		19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as #10											
2 2		20a. METHOD OF DISPOSITION t □ Burlel 2 XCremation 3 □ Remove 4 □ Donetion 8 □ Other (Specify)	of from State con	netery, crematory or	OF DISPOSITION (other place)			CATION — City or To						
death. Page 6 m funeral director, I.		21. SIGNATURE OF JUNERAL SERVICE LICENSEE Chesapeake Crematory 10-19 Beltsville, MD 22. NAME AND ADDRESS OF FACILITY Rapp Funeral Services, P.A.												
9 7 8		2.061_ B. (-	W	M00827	933 G	ist Ave,	Silver Spr	ring, MD	20910					
filled in by th on, or remove		23. AMT i. Enter the diseases, or con shock, or heert fellure. Lie	nplications that ceused at only one ceuse on e	d the death, Do ach line.	not enter the n	node of dying, suc	th as cardled or respi	ratory srrest,	Approximata Interval Batween					
a ∰ 00 €		IMMEDIATE CAUSE (Final disease or condition resulting in death)	amo	OXIC	Brain	u Inil	llaca		Oneet and Death					
B 2 2 5	_	resulting in death) o. AMOXIC Brain Injury DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions D. Motor Wehicle accident 23/laws												
ysician a prior to	CERTIFICATION	If smy, leading to immediate csuse. Enter UNDERLYING CAUSE (Disease or Injury												
th certi ending Hygie or oth	CERTIF	that initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE	OF):	D.CA	IPP CAT							
by the	AL	PART II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Part WAS AN AUTOPSY PERFORMED? AMILABLE PRIOR TO												
requires the een signed of Health a	MEDIC				<u> </u>			KNO	OF DEATH?					
e law requires th has been signed Dept. of Health	N:	DID TOBACCO USE CONTRIB	BUTE TO CAUSE O	F DEATH Y	ES NO I	UNCERTAI	 N		1 TYES 2 NO					
는 a a a	PHYSICIAN:		IQSPITAL:		ATH (Check only on	e)								
certification the	HYS	1 YES 2 NO 27. MANNER OF DEATH	Inpittlent 2 ER/Outp	28b. TI	ME OF 28c. II	HURY AT	8 Other (Specify) 26d. DESCRIBE HOW II	NJURY OCCURED						
	ВУ Р	1 Netural 5 Pending 2 Accident Investigation	octobers 15,	1995 6		YES 2 NO	Motor Veh	ich Acci	oon t					
OR ATTENDING DIRECTOR: After hours after death item 28 is ma		3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF INJURY building, atc. (Spec	- At home, form.	street, factory, off	lce	28t. LOCATION (Street a City or Town, State)		Route Number,					
DIR.	PLET	29e. CERTIFIER (Check only	N: To the best of my know			te end piece, end due		TIMORE,	MARYLAND					
THE HOSPITAL THE FUNERAL filed within 72 PORTANT: II	COMPLETED	one) 2 MEDICAL EXAMINER: (On the basis of examination						end menner ee stated.					
TO THE HOSPI TO THE FUNER be filed within IMPORTANT:	TO BE	296. SIGNATURE AND TITLE OF CERTIFIER Downs Dyolu 30. NAME AND ADDRESS OF PERSON WHO CO	COMPLETED CAUSE OF DE	ATH (ITEM 27) (See	a Print	D 431	MBER //	Detail	(Month, Day, Your)					
7		600 NORTH WOLF			LTMOS	F MA	RULANK	212	87					
		31. DATE FILED (Month, Day, Year) OCT 2 7 1995	32. REGISTRAR'S SIGN	ATLINE										
		00 1 1 1333	1						DHMH-18 Rev 1/89					



BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. A hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunat-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlat, cremation, or removal.

IMPORTANT: If Nem 28 is marked, or Nem 23 shows any Injury, or other traumatte event, the medical examiner must be neitfled at once.

FOR STATE REGISTRAR 1 -

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEDENT'S NAME (First, Middle, Last)									2. DATE OF DEATH DAY OCTOBER 26, 1995 3. TIME OF DEATH 1:10 A M					
- 1	A SOCIAL SECURITY NUM	Patricia A. Simmor						1				0, 1:			- 111
	267-76-6325		5. SEX	6. AGE (In yrs	s. last birthday) YRS,	MONTHS	DAYS	HOURS	MIN.	7. DATE OF (Month,	28,19	943	Count	HPLACE (State or Firy) nington,	
	Se. FACILITY NAME (If not i	natitution, give s	street end number)			9b. CIT	Y, TOWN	OR LOCATI	ON OF D		9c. COUNTY OF DEATH				
DIRECTOR	6901 Wilson					В	Beth	esda				Mon	ntgo	mery	
2	RESIDENCE OF DE	10b. COUNT	Υ		10c. Cf	TY, TOWN	OB LOCA	ITION						10d. INSIDE CIT	v
	Maryland	Mont	gomery		1120	thes						LIMITS? 1 YES 2 X NO			
A	10e. STREET AND NUMBER						10	of. ZIP COD	E					WHAT COUNTRY?	
	6901 Wilson	Lane						2081	.7			Uni	ted	States	
BT FUNERAL	11. MARITAL STATUS 1 Never Merried 2 3 Dividowed 4 Div			NT EVER IN U.S I YES 2 WAR OR DATES	XNO	13.	If yes, s		ın, Mexici	NIC ORIGIN? in, Puerto Ric y:		or No-	14. RAC Blac Spec	E — American Ind k, White, etc.	len,
2	15. DE	CEDENT'S EDU	ICATION	184	DECEDENT'	S USUAL C	OCCUPAT	ION		16b. F	KIND OF BUS	SINESS/IND	USTRY		
	Elementary/Secondary	ly highest grade	College (1-4 or 5	+)	(Give kind of life. Do NOT	work done use retired.)	dunng m	nost of works	ng						
COMPLE	12		_		Homema	aker				C	wn Ho	me			
5	17. FATHER'S NAME (First, I	Middle, Last)						18. MOT	HER'S NA	ME (First, Mil	ddle, Meiden	Sumeme)			
	John Clare	ence Ga	arner					N	fary	Josep	hine	Smit	h		
20	194. INFORMANT'S NAME				19b. MAILIN	G ADDRES	S (Street	end Numbe	r or Rural	Route Numbe	r, City or Town	n, State, Zip	Code)		
2	Francis Led	ldy Sin	nmons							hesda				817	
	20a. METHOD OF DISPOSI 1 X Burlal 2 Cremati 4 Donation 8 Other	ion 3 🗆 Rem	noval from State		ACE AND DATE y, crematory or of He					995 PATE		ver S		own, State ng, Mary	land
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE M00689 22. NAME AND ADDRESS OF FACILITY Robert A. Pumph Home/Bethesda-Chevy Chase, Inc. Wisconsin Avenue, Bethesda, MD							nc.	7557						
CERTIFICATION	Ovarian Cancer Due to (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING Ovarian Cancer Due to (OR AS A CONSEQUENCE OF):														
EMILLI	CAUSE (Disease or Injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF):														
. 1	PART ii. Other aignific	ent condition	ns contributing to	deeth but r	not resulting	in the u	Inderlyl	ng cause	given in	Pert I.	24a, WAS AN		24	b. WERE AUTOPSY	FINOINGS
											PERFOR			AVAILABLE PRIOR COMPLETION OF OF OEATH?	
C.														1 TYES 2 X	NO
-	DID TOBACCO I	JSE CONT	RIBUTE TO CA	AUSE OF D	EATH Y	ES 🗆	NO I	VIV	CERTAI	N 🗆					
2	25. WAS CASE REFERRED	TO MEDICAL		26. 1	PLACE OF DE	ATH (Check	k only one	9)							
2	EXAMINER?		HOSPITAL:	☐ ER/Outpatie	nt 3 🗆 DOA	OTHE	ER:	me 5 X F	lesidence	8 Other	(Specify)				
PHISICIAN	27. MANNER OF OEATH 1 X Netural 5	Pending	28e. DATE O (Month,	F INJURY Day, Year)	28b. TI	-	28c. If	NJURY AT YORK?			CRIBE HOW I	NJURY OC	CURED		
בח פז	2 Accident 3 Suicide 8	2 Accident Investigation 3 Suicide 8 Could not be 28e. PLACE OF INJURY — At home, farm building, etc. (Specify)									TION (Street Town, Stete)		r or Rural	Route Number,	
COMPLETED	anal	29e, CERTIFIER (Check only 1 🔀 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner ee stated.													
BE CO	296. SIGNATURE AND TITL			1/	4			29c. LIC	ENSE NU			29d. DAT	E SIGNE	D (Month, Day, Year)
2	30. NAME AND AGORESS							D04		Doctober 26, 1995					
	Daniel Ros		, M.D. 10	0400 C	onnect	icut	Ave	enue,	Ken	singt	on, M	ary1a	and	20895	
	OCT 27 19	95	ulia Dandi	AR SIGN TU	T.		,								

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Pages 1, 2, 3 should

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funeral director,

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RECORDS, P.O. I	requires
TAL	The law re
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DIVISION OF VITAL	ATTENDING PHYSI
	OR
_	SPITAL

this certificate h with the State [

After

DIRECTOR: A

Smith S. Ho,

23 1995

31. DATE FILED (Morith, Day, Year)

M.D.

32. REGISTRAR'S SIGNATURE

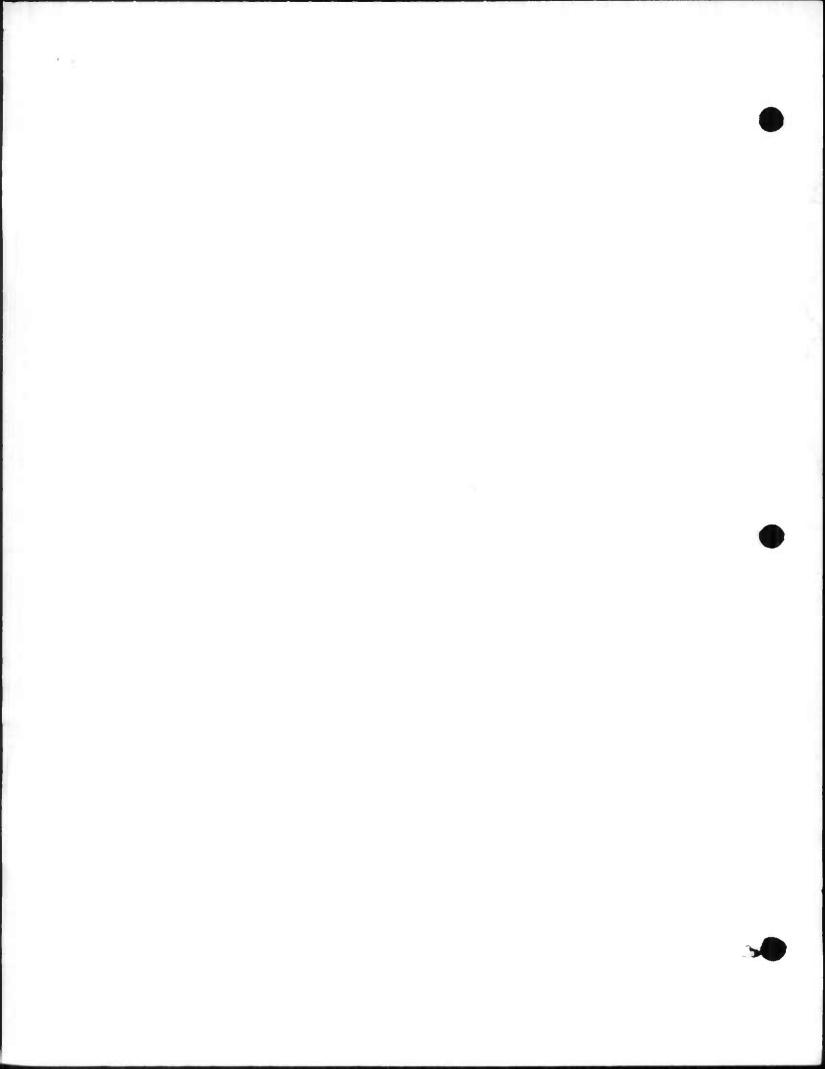
a Stucker Reveall

HOSPITAL

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 1995 Ann M Smith October 20 1:20 PM 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year 5 SEX 6. AGE (In yrs. lest birthday IF UNDER 1 YEAR 8. BIRTHPLACE (State or Foreign IF UNDER 24 HRS. 1 🗌 M 2 🖵 F YRS. 578-02-5082 Pennsylvania May 4, 1903 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Althea Woodland Nursing Home Silver Spring Montgomery RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Maryland Montgomery Silver Spring 1 YES 2 NO FUNERAL 10a. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 1000 Daleview Drive 20901 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. 1 Nover Married 2 Merried If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 TES 2 NO Specify: BY Specify: 3 Widowed 4 Divorced White COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highe Elementary/Secondary (0-12) College (1-4 or 5+) 11 Librarian Federal Government 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Sumame) 7 BE Edwin Smith May Unknown notified 19a. INFORMANT'S NAME (Type/Print) 19b, MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Margaret Farthing 416 Hungerford Drive #420 Rockville, Maryland 20850 pe 20a, METHOD OF DISPOSITION
1 Buriel 2 Cremation 3 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must Columbia Gardens Cemetery 10/23/95 4 Donation 5 Other (Specify) Arlington, Virginia examiner 21. SIGNATURE OF FUNERAL SE RVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. has been signed by the attending physician and completely filled in by the 123 shaues are 123 shaues. 500 University Blvd., W. Sil.Spr., MD 20901 medical 23. PART / Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata shock, or heart failure. List only one cause on each line. interval Betw IMMEDIATE CAUSE (Final Onset and Death 韩 disease or condition resulting in death) Aplastic Anemia 5 Years event, DUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION Hypertension 10 Years Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events reaulting in death) LAST 6 Injury, PART II. Other aignificant conditions contributing to deeth but not resulting in the underlying cause given in Part I. MEDICAL 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE 24s, WAS AN AUTOPSY PERFORMED? any 1 TYES 2 X NO OF DEATH? shows 1 TYES 2 T NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Hem HOSPITAL OTHER: 1 YES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 4 ☑ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) 0 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? marked, 28d, DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, farm, street, fectory, office building, etc. (Specify) 3 Suicide .00 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) ED 8 Could not be 4 Homicide 28 COMPLET Tem! 29a. CERTIFIER 1 XCERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. (Check only one) FUNERAL within 72 h TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: II 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 28/201.2 D 21900 9 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

7610 Carroll Avenue #280 Takoma Park, Maryland 20912





BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760 HOSPITAL O FUNERAL DI WITHIN 72 ho

COMPLETED

BE

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TO THE HOSPITAL.
TO THE FUNERAL IDE filed within 72 h

. OR ATENDING PHYSICIAN: The law requires that the death certificate be executed within continued to a may be retained by the hospital or attending physician.	
DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buriat-transit permit perms 1 2 3 should	
hours after death with the State Dept, of Health and Memai Hygiene prior to burial, cremation, or removal.	
item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at ones.	

95 33778 Items10a-10f 12-26-95 FilmG730 W.H.Per F/H STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH OUT YEAR Yemna Salih 995 10:52 PM 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) 7. DATE OF BIRTH (Month, Day, Too) 1898 IF UNDER I YEAR 8. BIRTHPLACE (State or Foreign DAYE HOURS 1 M 2 F 97 Florida 192-22-4740 YRS. 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 914 College Parkway Rockville, Montgomery RESIDENCE OF DECEDENT 10a. STATE Pa. 10c. CITY, TOWN OR LOCATION Philadelphia 10b. COUNTY Philadelphia 10d. INSIDE CITY Maryland Montgomery. Pockville 1 X YES 2 NO FUNERAL 2417 N. 10th Street 914 College Parkway 10f. ZIP COOE 10g. CITIZEN OF WHAT COUNTRY? 19122 20850 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 24-2NO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married IF YES, GIVE WAR OR DATES 1 TES 2 NO Specify: Specify: BY 3

Widowed 4 □ Divorced Arab COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) 7th Housewife None 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname) Unk. Unk BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING AODRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Nephew) 2 Mr Abdul Malik 914 College Parkway, Rockville, Md 20850 20s. METHOD OF DISPOSITION
1 Disposition | Method | Removal from State | Donation | S | Other (Specify) | 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION - City or Town, State Mikal, Sof Funeral Palor 10/23 Atlantic City, N.J 22. NAME AND ADDRESS OF FACILITY Snowden Funeral Home P.A. 20850 21. BIGNATURE OF FUNERAL SERVICE LICENSE 22. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or their fellure. List only one cause on each line. 246 N. Washington St, Rockville, Md Approximate interval Between IMMEDIATE CAUSE (Finel Onset and Death disease or condition_ etastatic colon carcinomo reaulting in death) month CERTIFICATION Sequentielly ilst conditions, DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST PART il. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part i. PHYSICIAN: MEDICAL 24a. WAS AN AUTOPSY PERFORMEO? 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 NO OF DEATH? 1 - YES 2 1 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES 🗀 NO 🗷 UNCERTAIN 🗆 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL:
1 | Inpetient 2 | ER/Outpetient 3 | DOA OTHER: 1 YES 2 NO 4 - Nursing Home 5 - Residence 8 - Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE NOW INJURY OCCURED 1 X Netural M 1 YES 2 NO BY

2 Accident 28s. PLACE OF INJURY — At home, ferm, street, factory, office building, atc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be 4 Homicide 29e. CERTIFIER (Check only 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(e) and manner ea stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFICATION 29c. LICENSE NUMBER 29d. DATE SIGNEO (Month, Day, Year) 31391 Dogober, 22,1995 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 841 N. Frederick Ave-Gaillesburg, MD 20877- Swife 230 5. Abulforag, MD 31. DATE FILED (Month, Day, Year) 32, REGISTRAR'S SIGNATURE 23 1995 Talia Davidson Rendall DHMN-18 Rev 1/89

YEAR 1995

9c. COUNTY OF DEATH

3. TIME OF DEATN

10d. INSIDE CITY LIMITS?

14. RACE — American Indian, Black, White, atc.

20680

interval Between Onset and Death

MIN.

24b. WERE AUTOPSY FINDINGS

AVAILABLE PRIOR TO

1 YES 2 NO

COMPLETION OF CAUSE OF DEATH?

1 YES 2 K NO

White

8. BIRTHPLACE (State or Foreign

Wisconsin

Montgomery

10g. CITIZEN OF WHAT COUNTRY?

Specify:

USA

9:40 P M

REG. NO.

2. DATE OF DEATN

October 19

FOR STATE REGISTRAR

Irene

4. SOCIAL SECURITY NUMBER

329-09-5283

1. DECEDENT'S NAME (First, Middle, Last)

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7. DATE OF BIRTN (Month, Day, Year) July 9, 1909 Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATN Fairland Nursing Home DIRECTOR Silver Spring RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10a. STATE Maryland St. Mary's Ridge the burial-transit permit. 10e. STREET AND NUMBER FUNERAL 101. ZIP CODE P. O. BOX 225 Curley's Road 20680 within 24 hours after death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 X NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea or No—If yea, specify Cuben, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify: 1 Never Married 2 Merried BY 3 X Widowed 4 Divorced use as 1 COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY μÕ Elementary/Secondary (0-12) College (1-4 or 5+) should be detached Secretary Labor Relations Board once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First Middle Maiden Sumame) notified at Julian Doda Stanislawa Unknown BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Edward C. Sokolowski P.O. Box 225 Curley's Road, Ridge, MD be 20s. METHOD OF DISPOSITION
1 Surlet 2 Cremation 3 Ramoval from State
4 Donalion 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 10/23/95 ATE 20c. LOCATION - City or Town, State must the funeral director, Washington National Cemetery Suitland, MD examiner 21. SIONATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. Homes 500 University Blvd.W. Sil.Spr.MD 20901 filled in by the figure, or removal. 23. PART I unter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, sock, or heart failure. List only one ceuse on each line. medical IMMEDIATE CAUSE (Final the disease or condition сгетатоп, LORONARI completely resulting in death) traumatic event, DUE TO (OR AS A CONSEQUENCE OF executed burial, CERTIFICATION and Sequentially list conditions, signed by the attending physician a Health and Mental Hygiene prior to if any, leading to immediate pe cause. Enter UNDERLYING CAUSE (Disease or Injury OROMAR certificate other 1 DUE TO (OR AS A CONSEQUENCE OF) thet initiated eventa reaulting in death) LAST 50 Injury, PART II. Other significent conditions contributing to deeth but not resulting in the underlying ceuse given in Pert I. 24a. WAS AN AUTOPSY MEDICAL PERFORMED? /USIONA any 1 YES 2 1 NO 23 shows LAUCOMA this certificate has been with the State Dept. of H DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: DR ATTENDING PHYSICIAN: The law 28. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL OTHER:
4 M Nursing Home 5 Residence 8 Other (Specify) HOSPITAL: 1 YES 2 NO Inpetient 2 ER/Outpetient 3 DOA 10 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK?
1 YES 2 NO 28b. TIME OF 28d. DESCRIBE HOW INJURY OCCURED marked, 1 🕅 Naturel BY After death 2 Accident Investigation O THE HOSPITAL DIRECTOR: Africa filed within 72 hours after de "Arangel Trans." Il tem 28 is 28e. PLACE OF INJURY — At home, larm, atreet, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be determined ED 4 Nomicide COMPLET 29a. CERTIFIER (Chack only (Ch TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: II 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 296, SIGNATURE AND TITLE OF CERTIFIER BE 2 30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27 1/1/20) 14440 CHERRY LA CT #100 LAUREL MD 2070; 31. DATE FILED (Month, Day, Year) OCT 23 1995

Sokolowski

6. AGE (In yrs. last birthday)

86

5. SEX

1 M 2 XF

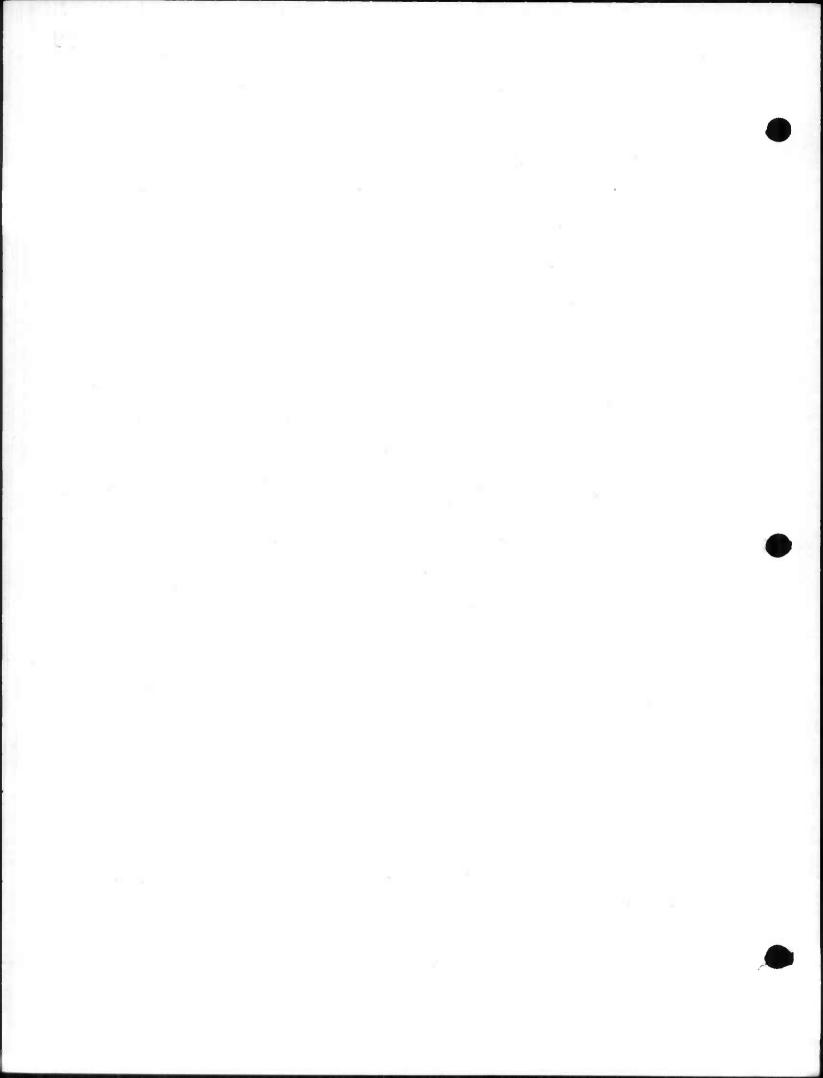
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

DAYS

IF UNDER 24 HRS.

HOURS

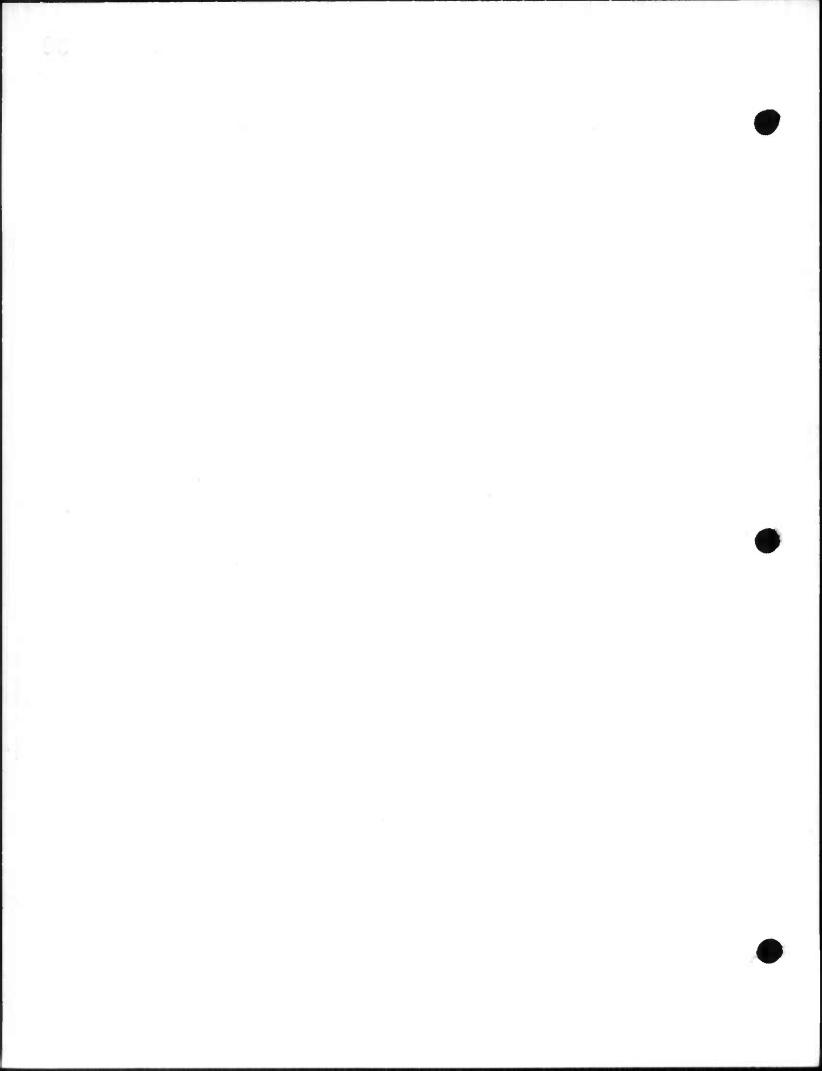
DHMH-16 Ray 1/89



DIVISION OF VITAL RECORDS, P.O. BOX 68760

	TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	0 THF FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	be filed within 72 hours after death with the State Dept. of Health and Memtal Hygiene prior to burial, cremation, or removal.	IMPORTANT: It liem 28 is marked, or liem 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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	1 - FOR STATE REGISTRAR	STATE OF MA	ARYLAND C	DEPAR	TMEN'	OF H	IEALTH AI	ND ME	NTAL HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Last)								DATE OF DEATH		T	3. TIME OF DEATH
	Mary Bernard Stu	rm							October 1	9. 1	YEAR 995	5:25r
	4. SOCIAL SECURITY NUMBER		AGE (In yrs. le	st birthday)	IF UNDER		IF UNDER 24	HRS. 7.	DATE OF BIRTH (Month, Day, Year)			PLACE (State or Foreign
	091-05-6406	1 ☐ M 2 🄀 F	78	YRS.	WONTHS	DAYa	HOURS	A A		1917		klyn, N.Y
œ	9a. FACILITY NAME (If not institution, give				9b. CITY	, TOWN	DR LOCATION	OF DEATI	н	9c. COL	INTY OF DE	EATH
DIRECTOR	Shady Grove Adver		tist Hospital Rockville								ntgo	mery
R	10a. STATE 10b. COUNT	Total on Education							10d. INSIDE CITY LIMITS?			
	New York Suffe	erhe	ad						1 TES 2 X NO			
FUNERAL	10e. STREET AND NUMBER					101	ZIP CODE			10g. CIT	IZEN OF W	HAT COUNTRY?
NE NE	38 Birch Court						11901					States
	1 Never Married 2 Married	12. WAS DECEDENT FORCES? 1 2 IF YES, GIVE WAI			If yes, sp	ecify Cuban, N	lexican, P	ORIGIN? (Specify Ye Puerto Rican, stc.)	e or No—		- American Indian, Whita, etc.	
В	3 Widowed 4 Divorced	NOWN							Specif	White		
COMPLETED	1S. DECEOENT'S EDU (Specify only highest grade	CATION (completed)	16a, D	ECEDENT'S	USUAL O	CCUPATIO	ON st of working		16b. KIND OF BU	SINESS/IN	DUSTRY	WHITE
	Elementary/Secondary (0-12)	College (1-4 or 5+)	iii.	. Do NOT us	e retired.)	ourny mo	st or working					
MP	12		Ass	istar	it to	th	e Edit	or	Magazi	ne Pı	ublis	her
8	17. FATHER'S NAME (First, Middle, Last)						18. MOTHER	'S NAME	(First, Middle, Melder	Sumame)		
BE	Andrew Maslanka						Mary			UNKN		
5	19a. INFORMANT'S NAME (Type/Print)								Number, City or Tov			
	Millard L. Sturm		$\overline{}$	AND DATE				erne	ead, N.Y.			
	1 K Burial 2 Cremation 3 K Rem 4 Donation 5 Other (Specify)	noval from State	cematery, cr	ematory or ot	her place)			1			City or Tov	
	21. SIGNATURE OF FUNERAL SERVICE LJ	CENSEE	TCaive	rton	Nati	Ona.	L Cem.	OF FACILI	™ DeVol	verto	on, N	· Y ·
	1 254				10) Eas	st Dee	r Pa	rk Drive	rune	rai i	iome
_	20 PART STATE OF THE STATE OF	3			Ga	ith	ersbur	g, M	D 20877			
	23. PART I. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, auch sa cardisc or respiratory arrest, shock, or heer feliure. List only one cause on each line.										Approximate interval Between	
	iMMEDIATE CAUSE (Single)										Onset and Da	
	resulting in death)	. Cardiac	Arrest									Minute
_	_):							
0	Sequentially list conditions, if any, leading to immediate b. Pulmonary Arrest Due TO (OR AS A CONSEQUENCE OF):										Minute	
CERTIFICATION		Massive	Intra	ntracerebral Hemorrhage								1 Day
	that initiated events	DUE TO (O	R AS A CONSE	OUENCE OF):							1 Day
	resulting in death) LAST	d										
A C	PART ii. Other aignificent condition	na contributing to d	eath but not	resulting i	n the un	derivino	ceuse give	n in Par	1 1. 24s, WAS AN	AUTOPSY	24h	WERE AUTOPSY FINDIN
									PERFO	RMED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE
MEDIC									_ 1 □ YES	∑ NO		OF DEATH?
≥	DID TOBACCO USE CONT	RIBUTE TO CAU	SE OF DEA	TH YE	s 🗆 i	VO F	UNCER	TAIN I				1 TES 2 X NO
Ž	25. WAS CASE REFERRED TO MEDICAL			CE OF DEAT			OTTOLK	17-471				
Sic	EXAMINER? 1 YES 2 X ND	HOSPITAL:	R/Outpatient :	DOA	OTHER		e 5 🗆 Reside	nce 8	Other (Specify)			
PHYSICIAN:	27. MANNER OF DEATH	28e. DATE OF IN (Month, Day,		28b. TIMI	OF	28c. INJ		_	d. DESCRIBE HOW	NJURY OC	CUREO	
BY	1 Netural 5 Pending 2 Accident Investigation	(Month, Edy,	rour,	Ino	M		ES 2 N	0				
	3 Suicide 8 Could not be	28e. PLACE OF building, st	NJURY — At he	ome, ferm, s	treet, fact	ory, offic		28	f. LOCATION (Street City or Town, State	and Number	r or Rural Ro	oute Number,
	4 Homicide determined								ony or rown, orang,			
COMPLETED	29e. CERTIFIER (Check only 1 🔀 CERTIFYIND PHYSI	ICIAN: To the best of m	y knowledge, de	eath occurre	d at the t	lme, data	and place, and	d due to t	the cause(a) and me	nner as ste	ted.	
8		R: On the basis of exam										and manner as stated
w I	296 SIGNATURE AND PITLE OF CENTIFIE	W /					29c. LICENS	E NUMBEI	R	29d. DAT	E SIGNED	(Month, Day, Year)
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임	MAME AND ADDRESS OF PERSON WH	O COMPLETEO CAUSE	OF OEATH (ITE	M 27) (Type,	Print)							,,
	Takao L. Sato	11119 Rock	cville	Pike	Suit	e #	316, R	<u>oc</u> kv	ille, Ma	rylaı	nd 20	852
	31. DATE FILEO (MONTH, Day, Year) OCT 24 1995	32 REGISTRAR	SOMATURE									
	OC1 64 1995	and an annual or	- date design									
												DHMH-16 Rev



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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physic	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-t		IMPORTANT: It item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
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Pours	d ni ba	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	medi
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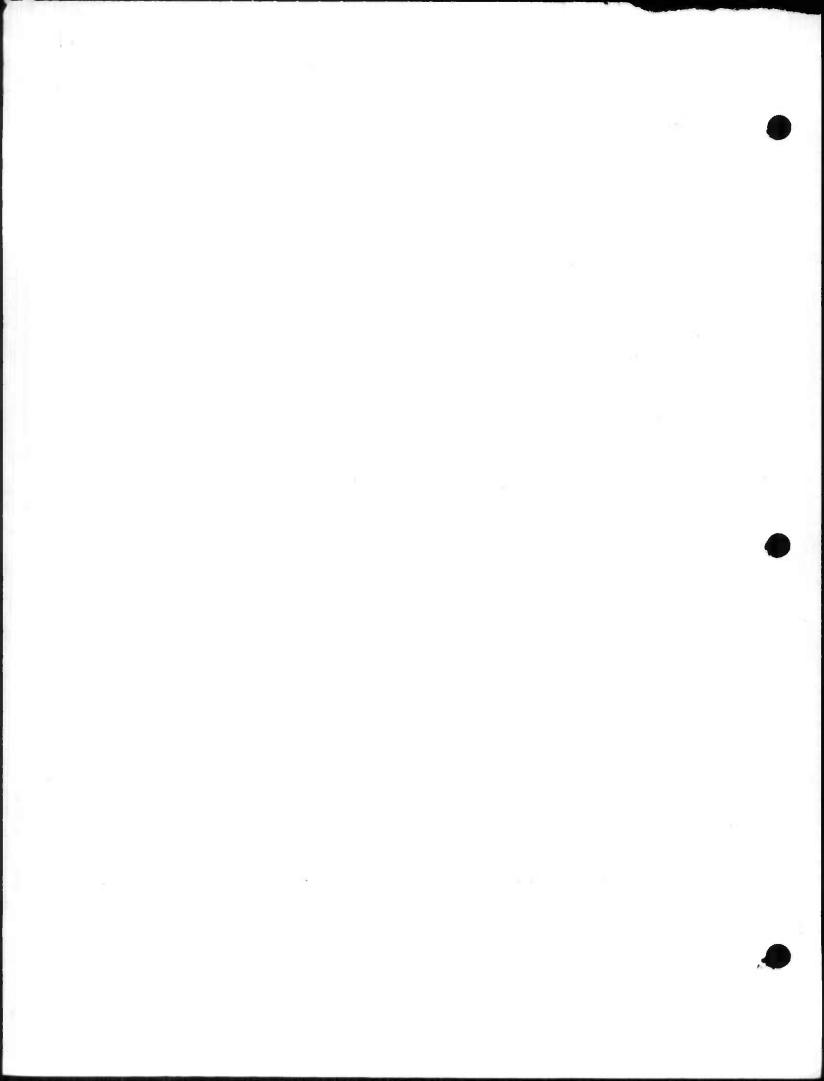
25 1995

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Kathryn Kistler Shratter October 1995 11:15 A M 23 7. DATE OF BIRTH (Month, Day, Year) Feb. 26, 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 5. SEX IF UNDER 1 YEAR 8. BIRTHPLACE (State or Foreign IF UNDER 24 HRS. 1 M 2 TF 67 186-20-2217 Pennsylvania 1928 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 2503 North Gate Terrace DIRECTOR Silver Spring Montgomery RESIDENCE OF DECEDENT tos. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Alabama Madison Huntsville 1 YES 2 K NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 2112 Mythewood Drive 35803 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, Whits, atc. 1 Never Married 2 Married If yes, specify Cubsn, Msxicon, Puerto Rican, etc.) t TYES 2 K NO Specify: Specify BY 3 Widowed 4 Divorced White ETED 16s. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-t2) Callege (1-4 or 5+) COMPL 3 Homemaker Own Home 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Sumame) Alan Kistler Margaret Ward BE 19s. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Benjamin Shratter 2112 Mythewood Dr., Huntsville, Ala. 35803 20a, METHOD OF DISPOSITION
1

Burlel 2 Cremstion 3
Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, Stats Maple Hill Cemetery 10/28/95 Huntsville, ALA 4 Donstion 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Francis J. Collins Funeral Home, Inc. amore 500 University Blvd.W. Sil.Spr.MD 20901 23. PART I. Enter the diseases, or complications that coased the desih. Do not enter the mode of dying, such as cerdiec or respiratory arrest, Approximete shock, or heart fellure. List only one cause on IMMEDIATE CAUSE (Finel **Onaet and Death** disease or condition_ artinosciente thant Disease 1ears resulting in deeth) DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events reaulting in deeth) LAST PART II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS MEDICAL AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 - YES 2 NO OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) EXAMINER? OTHER:
4 | Nursing Home 5 | Residence 8 | Other (Specify) YES 2 NO ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 26d. DESCRIBE HOW INJURY OCCURED Natural 5 Pending Investigation t YES 2 NO BY 2 Accident
3 Suicide 28s. PLACE OF INJURY — All home, farm, street, factory, office building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be COMPLETED 4 Homicide 29s. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, data and placa, and due to the cause(s) and manner as stated 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE - 2- Joule D08546 95 oct . 23 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

John F. Tauber M. D. 8218 Wisconsin Ave. #318, Bethesda, MD 32. REGISTRAR'S SIGNATURE

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Amended #12, 10/30/95, MRT, Montgomery County STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 23,1995 Robert Sega1 October 8:25 AM 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 5. SEX IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign 1 X M 2 - F 579-07-1989 81 Feb. 14,1914 Virginia Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 505 Mansfield Road DIRECTOR Silver Spring Montgomery RESIDENCE OF DECEDENT 18c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? MD Montgomery Silver Spring permit. 1 TY YES 2 | NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? death. Page 6 may be retained by the hospital or attending physician. funeral director, page 5 should be detached for use as the burial-transit 505 Mansfield Road 20910 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1X YES 2 100 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, Whita, etc. BALTIMORE, MARYLAND 21215-0020 FORCES? 1X YES 24
IF YES, GIVE WAR OR DATES
WORLD WAR 1 Never Married 2 TMarried If yes, specify Cuban, Maxican, Puerto Rican, etc.)

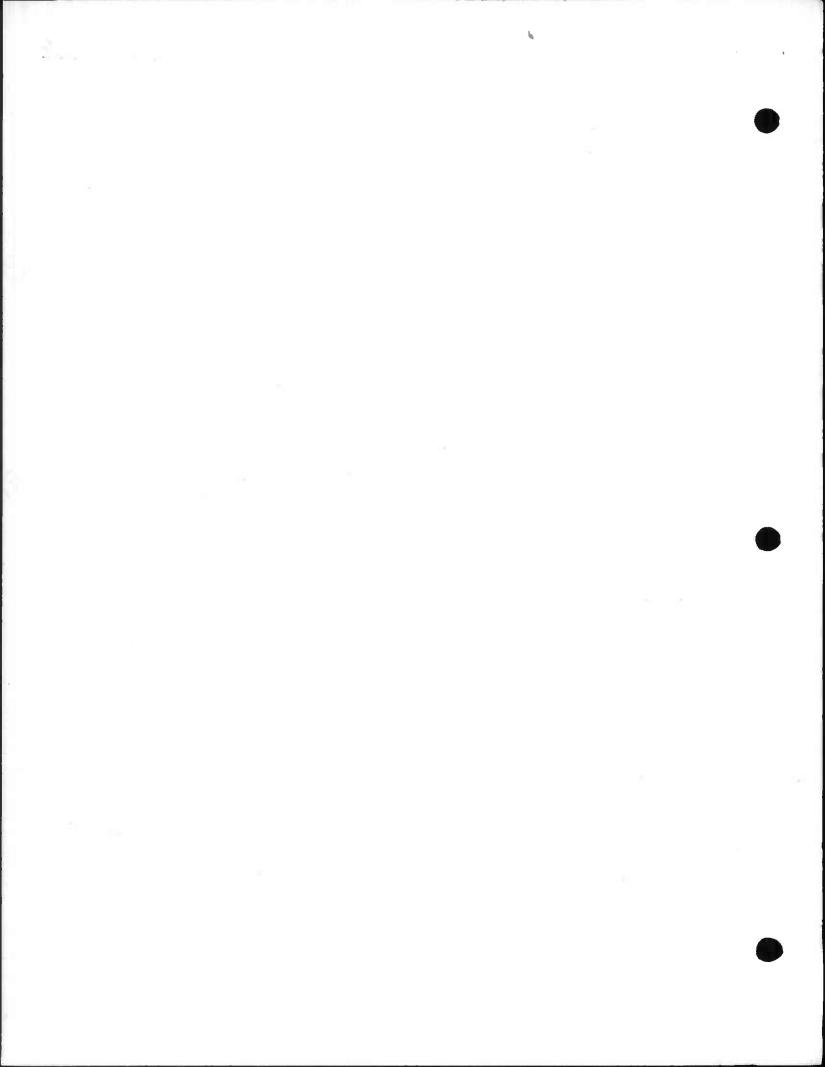
1 YES 2 NO Specify: BY 3 Widowed 4 Divorced White 15. DECEDENT'S EDUCATION ETED. 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Soi Elementary/Secondary (0-12) College (1-4 or 5+) 4+ Patent Examiner COMP Government 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname) Harry Segal Ħ Gertrude Ezer 86 notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Henrietta Segal 505 Mansfield Road Silver Spring MD 20910 hours after death. Page 6 may be must be 20s. METHOD OF DISPOSITION
1 Burial 2 M Cremation 3 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State Metrobolitian 10/25 Alexandria, VA 4 Donation 5 Other (Specify) the medical examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Edward Sagel Funeral Direction -1091 Rockville Pike Rockville, MD completely filled in by the rial, cremation, or removal. 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate ahock, or heart fallure. List only one cause on each line. Interval Between **IMMEDIATE CAUSE (Final** Onset and Death disease or condition Arrest CARDIAL resulting in death) traumatic event, DUE TO (DR AS A CONSEQUENCE OF): executed to burial, discuse Commany cuten CERTIFICATION and Sequentially list conditiona, DUE TO (OR AS A CONSEDUENCE OF): if any, leading to immediate attending physician death certificate be cause. Enter UNDERLYING CAUSE (Disease or Injury other DUE TO (OR AS A CONSEDUENCE DE): that initiated eventa resulting in deeth) LAST 0 the atter PART ii. Other aignificent conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE, been signed by the PERFORMED? 1 TYES 2 PONO OF DEATH? 1 | YES 2 | NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: has b 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Item DIRECTOR: After this certificate hours after death with the State HOSPITAL: OTHER: 1 TYES 2 NO 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 - Nursing Home 5 Residence 6 - Other (Specify) 0 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) marked, 26b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending м 1 YES 2 NO ВУ 2 Accident Investigation 28s. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide COMPLETED 8 Could not be 28 4 Homicide determined Item 8 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. TO THE HOSPITAL TO THE FUNERAL EDE filed within 72 h (Check only one) HOSPITAL 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and placa, and due to the cause(a) and manner as stated. 29th SIGNATURE AND TITLE OF CENTIFIER BE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 18594 161 2 SS OF PERSION WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 8886 CAMERON St Scite 601 MAUFMAN SI/VER SPRING WIS

OCT 24 1991

24 1995

NEGISTRAR'S SIGNATURE

Davidson Rawfall



								95	33	3783	
	1 - STATE REGISTRAR	STATE OF MARY		TMENT OF		MENTA	L HYGIEN	_			
	1. DECEDENT'S NAME (First, Middle, Lest)	IAY	711	400		2. DATE MONT	OF DEATH	14 19	YEAR 3.	1 SOP M	
	4. SOCIAL SECURITY NUMBER 577-84-4233	5. SEX 6. AGE	(In yrs. lest birthday) 93 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	(Mont	OF BIRTH th, Day, Year)		lary 1	ce (State or Foreign and	
OR	SO. FACILITY NAME (If not institution, give	SING CEN	TER	1	OR LOCATION OF DE		MRK	**X	Y OF DEATH		
DIRECTOR	10a. STATE 10b. COUNT			Y, TOWN OR LOCA					100	I. INSIDE CITY	
	Maryland St 100. STREET AND NUMBER	Mary's			gton Pa	rk		10e CITIZI		YES 2 NO	
FUNERAL		Great Mills Road 20653 USA									
BY FU	11. MARITAL STATUS 1 Never Married 2 Married 3 X Widowed 4 Divorced	FORCES? 1 YES	WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 NO If yes, specify Cuban, Maxican, Puerto Rican, etc.) 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. RACE-Black, Specify:							- American Indian, t, White, etc.	
TED	15. DECEDENT'S EDI (Specify only highest grad		16a. DECEDENT'S	work done durina n	ION lost of working	160	, KIND OF BUS	I SINESS/INDU	STRY	WILLE	
COMPLET	Elementary/Secondary (0-12) College (1-4 or 5 +) 6 Printer US Government										
SO	17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surneme)										
BE	Sanuel Thorne 19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street	Nedd and Number or Rurel I		aylor				
2	Nancy Lee Dul				ia Ct M					20695	
	2pa. METHOD OF DISPOSITION X Buriel 2 Cremation 3 Ren 4 Donation Donat (Specifi)		netery, cremetory or of the Linco	ther place)		27_0	95 Brei	CATION — CI			
	21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE	100173	22. NAME A	Eberwein	CILITY		TCWOOL	1101	yrana	
	John H.	Chance	-	11855	Holly La	a. #:	104 Wa	ldorf	MD 2	20601	
	23. PART . Enter the diseases, or shock, or heart fellure. IMMEDIATE CAUSE (Fine)	complications that cause List only one cause on a	d the death. Do s each line.	not enter the m	ode of dying, suc	h as cen	diac or respi	retory arres	et,	Approximate Interval Between Onset and Death	
	disease or condition resulting in death)	· Pmm	nmie	_					İ	weeks	
_		DUE TO (OR AS	A CONSEQUENCE O	F):							
ERTIFICATION	Sequentially list conditions, if any, leading to immediate	OUE TO (OR AS	A CONSEQUENCE O	F):							
FICA	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	cDUE TO (OR AS	A CONSEQUENCE O	F):							
	resulting in death) LAST	d,									
AL C	PART ii. Other significant condition	ns contributing to death i	out not resulting	In the underlying	ng cause given in	Part i.	24a. WAS AN PERFOR			RE AUTOPSY FINDINGS	
EDIC							1 YES 2	X _{NO}	OF I	PLETION OF CAUSE DEATH?	
N.	DID TOBACCO USE CONT	RIBUTE TO CAUSE C	OF DEATH YE	S NO [UNCERTAIN	v 🗆			1 [YES 2 NO	
PHYSICIAN: MEDICAL	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEAT	TH (Check only one QTHER:)						
HYS	1 YES 22 NO 1 Inpetient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 288. OATE OF INJURY 288. TIME OF 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED										
	27. MANNER OF DEATH		2 Accident Investigation M 1 YES 2 NO								
ВУ Р	1 Natural 5 Pending Investigation	(Month, Day, Year)									
ED BY	1 Natural 5 Pending	26s. PLACE OF INJURY building, etc. (Spe	— At home, farm, s			28f. LOC City	CATION (Street a or Town, State)	and Number or	Rural Route	Number,	
ED BY	1 Natural 5 Pending Investigation 3 Suicide 4 Homicide 8 Could not be detarmined 29e. CERTIFIER (Check only 1 CERTIFYING PHYS	26s. PLACE OF INJURY building, etc. (Spe	city)	street, lactory, offi	e and place, and due	In the car	or Town, State)	ner as steted	ı.		
COMPLETED BY	1 Natural 2 Accident 3 Suicide 4 Homicide 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINI 29b. SIGNATURE AND TITLE OF CERTIFIER 29b. SIGNATURE AND TITLE OF CERTIFIER	26s. PLACE OF INJURY building, etc. (Special Cidan): To the best of my know ER: On the bests of examinations	city) riedge, death occurre	street, lectory, offi ad et the time, dat on, in my opinion,	a and place, and dua death occured at the	In the cast	or Town, State) use(s) and man	d due to the	cause(s) end	menner as stated.	
ED BY	1 Natural 2 Accident 3 Suicide 4 Homicide 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINI 29b. SIGNATURE AND TITLE OF CERTIFIER 29b. SIGNATURE AND TITLE OF CERTIFIER	26s. PLACE OF INJURY building, etc. (Special Cidan): To the best of my know ER: On the bests of examinations	city) riedge, death occurre	street, lectory, offi ad et the time, dat on, in my opinion,	a and place, and dua death occured at the	In the cast	or Town, State) use(s) and man	d due to the	cause(s) end	menner as stated.	
BE COMPLETED BY	1 Netural 5 Pending Investigation 2 Accident 3 Suicide 4 Homicide 6 Could not be detarmined 29a. CERTIFIER (Check only one) 1 CERTIFYING PHYS ONE) 2 MEDICAL EXAMINI	28a. PLACE OF INJURY building, etc. (Special and a second	riedge, death occurring and/or investigation EATH (ITEM 27) (Type, 1465 6	ed at the time, dat on, in my opinion,	a and place, and dua death occured at the	In the cast	or Town, State) use(s) and man	d due to the	cause(s) end	menner as stated.	

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	HEGISTHAR		CERTIF	ICATE C	OF DEATH	REG. NO					
	1. DECEDENT'S NAME (First, Middle, Last)	1000				2. DATE OF DEATH					
		LIVIEV				Uctober	19,19	410WM M			
	The State of Cartesian		In yrs. lest birthday)	MONTHS DAY		7. DATE OF BIRTH (Month, Day, Year)	8. B	IRTHPLACE (State or Foreign ountry)			
	J11-24-0001	1 M 2 F	7.2 YRS.			Dec 19 1	922 Pa				
	9s. FACILITY NAME (If not institution, give stre	et and number)	. 1 1	9b. CITY, TOV	VN OR LOCATION OF D	EATH	9c. COUNTY				
Ö	North Aruno	lel Hosk	oital	Gle	n Burr	die	Ann	· Arundol			
្រូ	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		40.00	Y, TOWN OR LO							
DIRECTOR								10d. INSIDE CITY LIMITS?			
	MD Anne	Arundel	Se	verna	Park			1 TYES 2 THO			
FUNERAL					10f, ZIP CODE		10g. CITIZEN	OF WHAT COUNTRY?			
빌	401 Riggs Ave.				21146		USA				
교	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT EVER IN FORCES? 1 YES	2 NO	13. WAS	DECENDENT OF HISPAI , specify Cuban, Maxica	NIC ORIGIN? (Specify Yes	or No- 14, F	RACE — American Indian, Black, White, etc.			
B	3 XWidowed 4 Divorced	IF YES, GIVE WAR OR D	ATES	1 🗆	YES 2 NO Specif	y:		Specify:			
0	15. DECEDENT'S EDUCA	TION	16a. DECEDENT'S	Hellal occur	ATION	16b. KIND OF BUS	1	White			
1 6	(Specify only highest grade or	ompleted)	(Give kind of v	vork done during	most of working	160. KIND OF BUS	SINE 35/INDUSTR	17			
COMPLET	Elementary/Secondary (U-12)	College (1-4 or 5+)		ŕ	3.7						
O.	17. FATHER'S NAME (First, Middle, Last)	4	Regis	tered	Nurse	HOSDI ME (First, Middle, Maiden					
	James Ray Loude	20			100/14 - CA PEL N						
8	19a. INFORMANT'S NAME (Type/Print)		top Man me	ADORESS (S.		May Holl Route Number, City or Tow					
2	Luther G. Merri							•			
	20a. METHOD OF DISPOSITION					erna Pari					
	1 Buriel 2 X Cremation 3 Remov	al from State cem	PLACE AND DATE O	her place)			CATION — City of				
	21. SIGNATURE OF PUNERAL SERVICE LICER	vee	<u>letro</u> C		OTV	Ca	tonsvi	lle, MD			
	1/1/00					sons Fune	anal U	0 110			
	THE LA	anon	_					ark MD21146			
	23, PAST I. Enter the diseases, or cor ahock, or heart fellure. Life	mplications that caused	the deeth. Do n	ot enter the	mode of dying, suc	h aa cardlec or reapi	ratory arrest,	Approximate			
	IMMEDIATE CAUSE (Final	or only one ceuse on a	scn line,					Interval Between Onset and Death			
1	disease or condition resulting in death)	LUNG	CAN	1001	2			C. MONDA			
	resulting in death)	DUE TO (OR AS A	CONSEQUENCE OF):	-			U GAONTI			
z		LUNG CO	men	Met	USTASIS	70 AL	DOME	U / MOUTH			
유	Sequentially list conditions, If any, leading to immediate	DUE TO (OR AS A	CONSEQUENCE OF):		1					
2	CAUSE (Disease or Injury	ANEM	14					1 weca			
THE	that initisted events										
CERTIFICATION	resulting in death) LAST										
	PART II. Other significent conditions	contributing to death b	ut not resulting I	n the underl	ving ceuse given in	Part I. 24s. WAS AN	ALITOPSY	24b. WERE AUTOPSY FINDINGS			
EDICAL CE					,	PERFOR	MED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE			
						1 YES 2	NO	OF DEATH?			
Σ	DID TOBACCO USE CONTRI	DUTE TO CAUSE O	F DEATH VE	CUNO	C UNICEDIA!			1 TYES 2 NO			
AN	25. WAS CASE RETURNED TO MEDICAL		F DEATH YE			ן שני					
PHYSICIAN:	EXAMINER?	HOSPITAL:		OTHER:							
¥.	27. MANNED OF DEATH	Inpatient 2 ER/Outp	atient 3 L DOA 285, TIMI		fome 5 Residence	8 Other (Specify) 28d. DESCRIBE HOW II	N III DV COOLES				
	1 Natural 5 Pending	(Month, Day, Year)	INJ	JRY	WORK?	ZOG. DESCHIBE HOW II	NJURT UCCURE	,			
B	2 Accident Investigation 3 Suicide 8 Could not be	28e. PLACE OF INJURY	- At home form -			281, LOCATION (Street 4	and Musels - C	and Charles Marries			
	4 Homicide 8 Could not be	building, etc. (Spec	ify)		· · · · · · · · ·	City or Town, State)	ing Number of Hu	rei nutte Nuttiber,			
COMPLETED	29a. CERTIFIER										
MP	(Check only CEHTIFYING PHYSICIA	AN: To the best of my knowl									
8	2 MEDICAL EXAMINER:	on the beals of axamination	and/or investigation	ı, in my opinio	n, death occured at the	time, data and place, an	d due to the cau	se(a) and menner as stated,			
D BE COI	29h SIGNATURE AND TITLE OF CERTIFIER	1.10.	111		29c. HCENSE NUM	IBER /	29d. DATE SIGI	NED (Month, Day, Year)			
0	Mon (1- > WM	myedly.	July		102	8021	DOCT	050019,199			
F	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DE			4.		4 6	4.4			
	MAN M. SCHNEIBFE	OLA, M() 3	301 405	PITAL	- DLIVE,	0 LW 130	NU(E,	MANYLAND			
	31. DATE FILED (Month, Dey, Year)	32. REGISTRAR'S SIGNA			1			7-1061			
	OCT 2 6 1995	1. Havides	Radall					2.001			
		11	3					DHMH-16 Rev 1/8			

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death cartificate be executed within, 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL OHECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buntal-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	FOR STATE REGISTRAR	STATE OF MARYLA			F HEALTH		WENTAL HYGIENI REG. NO.	E		
	1. DECEDENT'S NAME (First, Middle, Lest) BABY BOY THORPE	OMARKO	ThoRp	2			2. DATE OF DEATH MONTH DA		YEAR 3.	11:58 A M
		1 M 2 🗆 F	r yrs. lest birthday) YRS.	- 6	EAR IF UNDER ANS HOURS DWN OR LOCATIO	MIN.	7. DATE OF BIFTTH (Month, Day, Year) OCTOBER 16,		8. BIRTHPL: Country) MARY	
TOR	UNIVERSITY OF MA	RYLAND HOSPI								
DIRECTOR	10e. STATE 10b. COUNTY	ARUNDEL.		NNA POL				d. INSIDE CITY LIMITS? YES 2 NO		
FUNERAL	100. STREET AND NUMBER				10f. ZIP CODE		- 1 - 3			T COUNTRY?
SNE	13 F BENS DRIVE	12. WAS DECEDENT EVER IN	U.S. ARMED	13. WA	2140		HC ORIGIN? (Specify Yes			American Indian,
ВУ	1 Never Married 2 Married 3 Wildowed 4 Divorced	FORCES? 1 YES			es, specify Cube YES 2 XNO		n, Puerto Rican, etc.)		Specify: BLA	CK
LETED	15. DECEDENT'S EDUCA (Specify only highest grade of Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT u	work done dur	JPATION ing most of workin	ng	16b. KIND OF BUS		USTRY	5.57
COMPLET	17. FATHER'S NAME (First, Middle, Lest)	0	NONE	:-	18, MOTI	HER'S NA	ME (First, Middle, Maiden			
BE C	OMAR WHITE						ERLY THORPE			
TO 8	19e. INFORMANT'S NAME (Type/Print)	_	19b. MAILING	ADDRESS (S	itreet end Number	or Rural i	Route Number, City or Town	n, Stete, Zip	Code)	
	SHIRLEY WHITE 200. METHOD OF DISPOSITION	100	906 C			ANI	NAPOLIS MI		401 City or Town	Chata
	1 N Buriel 2 Cremation 3 Removed	val from State cam	etery, crematory or NAPOLIS	other place)		10			LIS.	
	21. SIGNATURE OF FUNERAL SERVICE LICE		20	22. NA RE	ME AND ADDRES	SONS		P.A.		
	23. PART I. Enter the diseases, or co									Approximate interval Between
	IMMEDIATE CAUSE (Finsi disease or condition resulting in death)	disease or condition EXTERNE PREMATURITY								
		OUE TO (OR AS A								
ON	Sequentially list conditions, If any, leading to immediate PULLONARY HEWOLUHAGE DUE TO (OR AS A CONSEQUENCE OF):								2 days	
CAT	cause. Enter UNDERLYING CAUSE (Disease or Injury	GRADE IV		INTRAVENTILIEUCAR INFROMUNGE						
CERTIFICATION	that initiated events resulting in desth) LAST	PULLO NARY	zdays							
	PART II. Other eignificent conditions	contributing to death b	ut not resulting	In the unde	erlying cause	given in	Part I. 24s. WAS AN PERFOR	MED?	240. W	WAILABLE PRIOR TO OMPLETION OF CAUSE
MED										F DEATH?
N.	DID TOBACCO USE CONTR					ERTAI	ND			
SIC!	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 KNO	HOSPITAL:	26. PLACE OF DE	OTHER:						
Y PHYSICIAN: MEDICAL	27, MANNER OF DEATH 1 Natural 5 Pending	28e. DATE OF INJURY (Month, Day, Year)	28b, Til	-	Bc. INJURY AT WORK?		8 Other (Specify) 28d. DESCRIBE HOW I	NJURY OC	CUREO	
TED BY	2 Accident investigation 3 Suicide 6 Could not be determined	28e. PLACE OF INJURY building, stc. (Spec	— At home, farm,	street, factor	y, office		281. LOCATION (Street of City or Town, State)		or Rural Rou	ite Number,
COMPLET	COTTOCK OTHY	EAN: To the best of my known: On the best of examination								and menner ee stated.
8	296. SIGNATURE AND TITLE OF CERTIFIER PLUMS To Desbace	enjour HI	>,		D44407 >				DATE SIGNED (Month, Day, Year)	
10	30. NAME AND ADDRESS OF PERSON WHO TOWN TO CABACUNG AND , I	COMPLETED CAUSE OF DE	OF HANYU	on, Print) WD 405	prime, -	22 St	UTU SKHOVE S	Ty Pi	ипиор	E, MD 21201
	31. DATE FILED (Month, Day, Year) OCT 2 6 1995	22. REGISTRAR'S SIGN	Rarball							

	3 should	
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	I in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 or removal.	
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he death certhcate be executed within 24 hours after death. Pag	Se le	
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THE STATE OF	ertery	
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G PHYSICIAN: The law requires that the	er this certificate has been signed by the attending physician and completely filled in by to the State Dept, of Health and Mental Hygiene prior to bunal, cremation, or remov	
3	the	
2	nis c	
5	ith v	

	REGISTRAR		CE		CATE O			MENTAL HYGIEN REG. NO				
	1. DECEDENT'S HAME (First, Middle, Last) SOPHIE		OMA	-5		2. DATE OF DEATH MONTH	7 19	YEAR S	3. TIME OF DEATH 07 424			
		5. SEX 6.	AGE (In yrs. lesi		IF UNDER 1 YEAR			7. DATE OF BIRTH (Month, Dey, Year) AFRIL 13 1	916	Count	IPLACE (State or Foreign ry) YLAND	
	9e. FACILITY HAME (If not institution, give stre	eet end number)			9b. CITY, TOW	N OR LO	CATION OF DE			HTY OF D		
DIRECTOR	JOHN DEATON NURSIN	NG CENTER			BALTIMORE							
EC	10e. STATE 10b. COUNTY	_		10c. CITY,	TOWN OR LO	CATION					10d, IHSIDE CITY	
	MARYLAND ANNE A	ARUNDEL		AN	NAPOL						LIMITS? 1 XYES 2 NO	
FUNERAL											WHAT COUHTRY?	
S	302 CENTER STREET 11. MARITAL STATUS	12. WAS DECEDENT E	VER IH U.S. ARI	MED						USA	E — American Indian,	
ВУ	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 TITLE IF YES, GIVE WAR	OR DATES	0	If yes, specify Cuben, Mexican, Puerto Rican, etc.)					Black	K, White, etc.	
ETED	15. DECEDENT'S EDUCA (Specify only highest grade of Elementary/Secondary (0-12)	ompleted)	(Gi	ve kind of wo	T'S USUAL OCCUPATIOH of work done during most of working T use retired, I					DUSTRY		
APL.	8th_	College (1-4 or 5+)			COMMUNITY ACTION AGE						AGENCY	
COMPLET	17. FATHER'S HAME (First, Middle, Last)					10. 1	MOTHER'S HAI	ME (First, Middle, Maiden		TTON	MODITOI	
BE C	ALEXANDER HOLLAND						AMAND	A MILLER				
0	19e. IHFORMANT'S HAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)											
	JOSEPH THOMAS	AN MITHAD OF DISPOSITION										
	20e. METHOD OF DISPOSITION 133 Buriel 2 Cremation 3 Remov 4 Donation 6 Other (Specify)	val from State	cemetery, crer	netory or oth	er plece)			DATE 200. LO				
	21. SIGNATURE OF FUNERAL SERVICE LICE	HSEE	IAANNAP	OLIS	22. HAME	AND ADI	DRESS OF FAC	HUTY		113,	MD. 21401	
	Harry L	7. X.e	ese					ORTUARY, F NNAPOLIS,		2140	1	
	23. PART i. Enter the diseases, or co shock, or heart failure. Li	implications that colist only one cause	oused the dec	eth. Do no							Approximata interval Betw	
	IMMEDIATE CAUSE (Final disease or condition		. (-		20 1				Onset and De			
	resulting in death)	DUE TO COR	1 48 A CONOCO	1/9 by	ete,	m re	elit	5			746	
_	LA A DE A LA CONSEQUENCE OF):										10000	
<u> </u>	disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):										Buys	
8	cause. Enter UNDERLYING CAUSE (Disease or injury			en	brov	an	ula	a dise	esl		yre	
ERTIFICATION	that initiated events	DUE TO (OR	AS A CONSEO	UENCE OF):	of: ubrovagulan dises on: hyperters.m							
CER	resulting in desth) LAST			h							705	
4	PART II. Other algolificant conditions	contributing to de	eth but not re	sulting in	the underly	ing cau	ae given in i	Part I. 24s. WAS AN PERFOR		24b.	WERE AUTOPSY FINDIF	
MEDICA	- IF CVA D	ecuy 4	vs c	Lee	-16	>~	emi	1 YES 2	1		COMPLETION DF CAUS	
	hyper kel							/	/ \		1 _ YES 2 _ NO	
AN	DID TOBACCO USE CONTRI	BUTE TO CAUS			□ NO		NCERTAIN					
SICIAN:	EXAMIHER?	HOSPITAL:		_ ((Check only or OTHER:							
PHYS	27. MANNER OF DEATH	1 Inpatient 2 EF	URY	26b. TIME	OF 28c. I	NJURY A		26d. DESCRIBE HOW II	HJURY OO	CURED		
ВУ Р	1 Natural 5 Pending Investigation	(Month, Day, 1	rber)	INJU	RY	VORK?	2 NO	The state of the s				
60	2 Accident Investigation	26e. PLACE OF IN building, etc.	IJURY — At hon (Specify)	ne, ferm, str	eet, factory, of	fice		26t. LOCATION (Street a City or Town, State)	and Number	r or Rural R	loute Number,	
	290. CERTIFIER	AN: To the heat of my	knowledge des									
COMPL	(Check only one) 2 MEDICAL EXAMINER:							to the ceuse(s) and man) end manner se state	
E C	296. SIGHATURE AND TITLE OF CERTIFIER					29c.	LICEHSE HUM	BER			(Month, Day, Year)	
0 86	Portara 8	0 1		-			1289		> 0	ch 1	71995	
F	30. HAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE O	F DEATH (ITEM	27) (Type, P	Print) 91 0	10	60 m	-6 /-N.	7= 1) 10		
1	30. HAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print) 9101 Che vry Ly ## 211 8 PRITARY 5-50 171 MD LAURELY MD 2070 8											

31. DATE FILED (MONTH, GOC YO) 30 1995. REGISTBAR'S SIGNATURE Cardall

BALTIMORE, MARYLAND 21215-0020

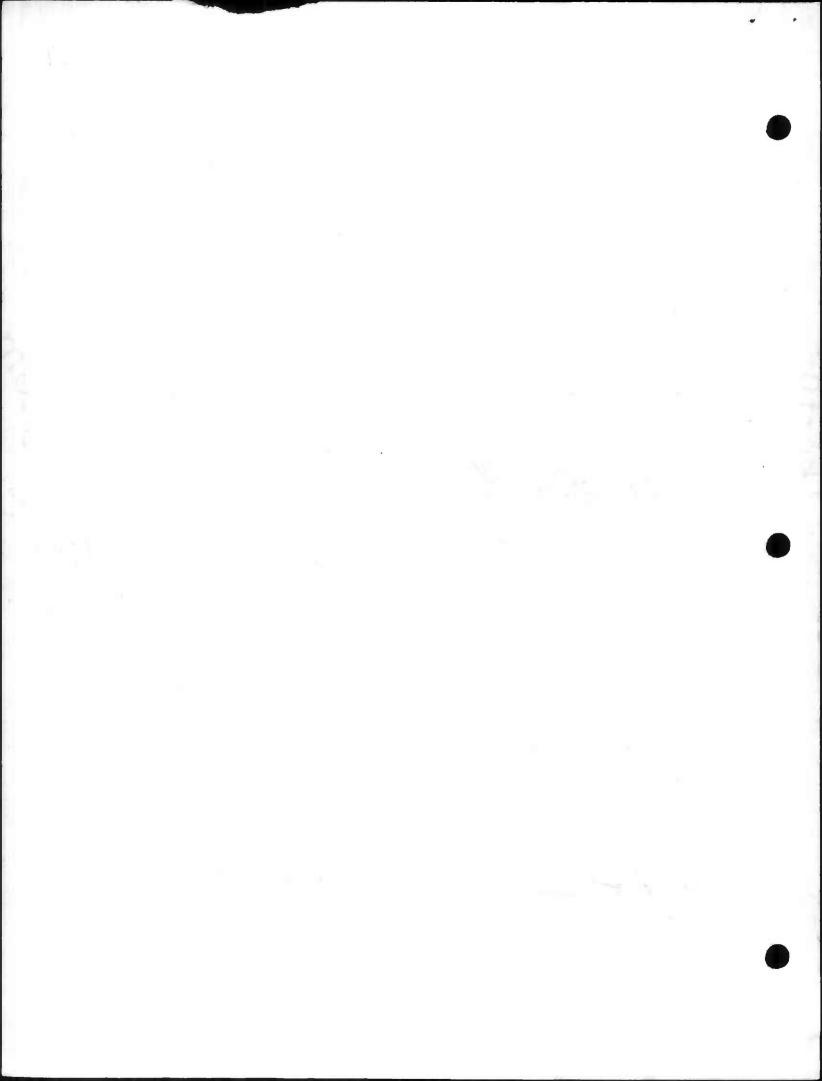
TO BE COMPLETED BY FUNERAL DIRECTOR

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.	
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1 - FOR STATE REGISTRAR		STATE OF MARYL				OF HEALTH AND OF DEATH	MENTA	L HYGIENI	Ε			
1. DECEDENT'S NAME (First,	Middle, Last)							OF DEATH			TIME OF DEAT	н
		Eleanor 7	roch	owski			Octo	ber 20		YEAR 5	1:10	a M
4. SOCIAL SECURITY NUMB	ER !	5. SEX 6. AGE	(In yrs. last		IF UNDER 1		7. DATE	OF BIRTH			ACE (State or Fo	
351 - 24 -	2313	1 M 2 X F	63	YRS.		DAYS HOURS MIN.	Nov	10, 19	31	Illi		
Suburban Ho	spital					esda			Mont			
10a. STATE	10b. COUNTY			10c. CITY,	TOWN OR	LOCATION				10	d. INSIDE CITY	
Illinois	Cook			West	ches	ter				,	LIMITS?	NO
10a. STREET AND NUMBER					00	10f. ZIP CODE			10g. CITIZE		T COUNTRY?	
11455 Ashle	y Drive	Woods				60154			USA			
11. MARITAL STATUS		12. WAS DECEDENT EVER			13. W	S DECENDENT OF HISPA	NIC ORIGI	N? (Specify Yes		4. RACE -	American India	ın,
1 Never Married 2 3 Widowed 4 Divo		FORCES? 1 YES		0		yes, specify Cuban, Maxic ☐ YES 2 🙀 NO — Spec		Rican, etc.)		Specify:	Vhita, etc.	
					<u> </u>						White	
	EDENT'S EDUCA highest grade co		(Gh	EDENT'S U	rk done du	CUPATION ring most of working	16	b. KIND OF BUS	INESS/INDU	STRY		
Elementary/Secondary (0		College (1-4 or 5+)	200	Do NOT use								
17. FATHER'S NAME (First, M.		<u>+</u>	Nur	sinq	Supe	rvisor		Public		h		
						18. MOTHER'S N						
Paul Trocho			101	MAH ING A	Depres /	Constai						
Katheryn Sc		~	- 1			ey Drive Wo				,	60154	
20a. METHOD OF DISPOSITI				-		ION (Name of			CATION - CI			
1 Durial 2 Cremetic	n 3 🕅 Ramov			natory or othe			1	24 Nile				
21. SIGNATURE OF FUNERA			JUL YI	ITTL (22. N/	AME AND ADDRESS OF F	ACILITY			TINO	18	
De 11.1	1170					naldson Fu						
NINU	afey	anty			31	3 Talbott	Ave.	Laurel	, Mar	yland	20707	1
23. PART I. Enter the di ahock, or h	ert ailura. Li	mplications that cause ist only one-cause on	d the dea	th. Do no	t enter ti	he mode of dying, su	ch aa ca	rdlec or reapi	ratory arre	nt,	Approxim	
IMMEDIATE CAUSE (Fir			,	0.	1m	na 1 1	1	1			Onset and	Death
resulting in death)	→ a.				11'(9	na. y f	188	es!			1/ho	JUF
		DUE-TO (OR AS	A CONSEO	UENCE OF		11:					1	
Sequentially list conditi		OUE TO ION AS	A CONSEQ	HENCE OF	a 5	of AcC.					-	
if any, leading to imme- cause. Enter UNDERLY		Lun	d	0	.0	0 -					1/2.	Λ
CAUSE (Disease or inju	iry 🥻 "	DUE TO (OR AS)	COMBEO	UENCE OF	1	V P					10 m	
resulting in death) LAS	Т)									
	- "										1	
PART II. Other algnifica	nt conditiona	contributing to death	but not ra	sulting in	the und	arlying causa given is	n Part i.	244. WAS AN PERFOR		Ai	ERE AUTOPSY FI MILABLE PRIOR	TO
								1 - YES 2	NO NO		OMPLETION OF (F DEATH?	AUSE
										1	YES 2 1	10
		BUTE TO CAUSE (IN 🗵					
25. WAS CASE REFERRED TO EXAMINER?		HOSPITAL:	26. PLACI	E OF DEATH	OTHER:							
1 TYES 2 NO		1 Inpatient 2 ER/Ou	petient 3	□ DOA .	l 🗌 Nursir	ng Home 5 🗆 Rasidence	6 COth	er (Specify)				
27. MANNER OF DEATH	Pending	(Month, Day, Year)		28b. TIME INJU	OF 2	ISC. INJURY AT WORK?	26d. OE	SCRIBE HOW II	NJURY OCCU	IREO		
	Investigation				M	1 YES 2 NO						
	Could not be determined	28a. PLACE OF INJUR building, etc. (Sp.	Y — Al hor ecify)	ne, ferm, str	est, factor	y, office	281. LO	CATION (Street a y or Town, State)	and Number o	r Rural Rou	te Number,	
29a, CERTIFIER								· -				
(Check only		AN: To the best of my kno : On the besis of examinati									nd manner es s	tated.
290. SENANDE SON FITLE	OF CENTIFIER					29c. LICENSE N	UMBER	10	29d. OATE	SIGNED (N	lonth, Day_Year)	
HELLS						D29	22	4	10	120	195	
30. NAME AND ADDRESS OF	Coy	COMPLETED CAUSE OF O	EATH (ITEN	1 27) (Type, F	Print)	Alver:	-Pr	uaj'	, m	0		
31. DATE FILED (Month, Day.	Year)	32. REGISTRAR'S SIG		TC		VIII	/	0				
OCT	2 3 199	5 Julia Day	den-A	andall								



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		1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.												
		1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH				DAY YEAR				
		SOCIAL SECURITY NUMBER 5. SEX 8 AGE (In use feet highway)				OCT.				-	1911	1:20 A		
		1. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) 172-14-9337 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1				IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF E				y, Year) Country)				
pinous		9e. FACILITY NAME (If not institution, give street end number)				9b. CITY, TOWN OR LOCATION OF DEATH				1920 Pennsylvania				
ND 21215-0020 hospital or attending physician. sched for use as the burial-transit permit. Pages 1, 2, 3 se.	CTOR	CHARLOTTE HALL VE		RLOTTE HALL ST MARY'S										
	12	10e. STATE 10b. COUNT	oc. CITY, TOW	OWN OR LOCATION 10d. INSIDE CITY						od. INSIDE CITY				
	ā	Maryland St Mary's			Charlotte Hall			t				☐ YES 2 1 NO		
	RAL	10e. STREET AND NUMBER			10f. ZIP CODE				10g. CITIZEN			AT COUNTRY?		
	FUNER	Route 2 Box 5 11. MARITAL STATUS 12. WAS DECEDENT EVER IN				WAC DE	20622		USA	A STATE OF THE STA				
		1 Never Married 2 Married FORCES? 1 YES			2 NO It yes, speci			ENDENT OF HISPANIC ORIGIN? (Specify Yee or No— ecify Cuben, Maxican, Puerto Rican, etc.)				14. RACE — American Indian, Black, White, etc.		
) BY	3 Wildowed 4 Divorced					t YES 2 NO Specify:					Specify: White		
	ETED	(Specify only highest grade completed) (Give)			tind of work done during most of working				6b. KIND OF BUSINESS/INDUSTRY					
		Elementary/Secondary (0-12)	College (1-4 or 5+) 5+		NOT use retired	retired.) Feacher			Public School					
	COMPI	17. FATHER'S NAME (First, Middle, Last)		TIGO.	ic ica	TICL	18. MOTHER'S NA	t, Middle, Meiden Surname)						
5 8 K	ш	Paul Nelson Teare Sr					Florence			Connainey				
₹ 8 5	TO B					SS (Street	end Number or Rural			n, State, Zip C	ode)			
. 4 8 0	F	Colleen J. Rigot		45	58 Crai	ne's	Roost Ct	Anr	apolis	, Mar	y1an	21401		
T B E E		20s METHOD OF DISPOSITION 1 DESCRIPTION 2 Cremetion 3 Rem	oval from State cam		DATE OF DISP		iame of	OA"	E 20c. LO	CATION — CH	ty or Town	State		
		Odd Fellows Cemetery 10-31-95 Milford, Delaware												
T in the little	- 3	1	2. NAME AND ADORESS OF FACILITY .H. Eberwein Mortuary											
th cardificate be executed within a hours after the cardificate be executed within a hours after and completely filled in by the I Hygiene prior to burial, cremation, or remova or other traumatic event, the medical		11855 Holly Lane #104 Waldorf, MD 206								20601				
		23. PAST. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiac or reapiratory arrest, shock, or heert failure. List only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): Approximate interval Batweet Onset and Death Approximate interval Batweet Onset and Death												
	CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initieted evants resulting in death) LAST b. Due to (or as a consequence of): c. Due to (or as a consequence of): d												
of the Me	占	PART II. Other algnificant conditions contributing to death but not resulting in the und					ng ceuse given in		AS AN AUTOPSY ERFORMED?		ERE AUTOPSY FINDINGS MILABLE PRIOR TO			
5 B E E	EDIC	AZHEMEN'S DISERSY							1 - YE\$ 2	NO		OMPLETION OF CAUSE F DEATH?		
requires seen sign of Heal	2	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES				Clare of the contract of					1	YES 2 NO		
has been sopp. of h	SICIAN:	25. WAS CASE REFERRED TO MEDICAL						иЦ				P. St.		
	SIC	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO												
PHYSICIA this certif with the rked, or	主	27. MANNER OF DEATH	28e. DATE OF INJURY		b. TIME OF	28c. IN	JURY AT		SCRIBE HOW I	NJURY OCCU	RED			
	ВУ Р	Netural 5 Pending (Month, Day, Year) 2 Accident Investigation					YES 2 NO							
TTENDI TOR: A affer de	ETED 6	3 Suicide 6 Could not be determined 26e. PLACE OF INJURY — At home, farm, street building, etc. (Specify)				et, factory, office 260			61. LOCATION (Street end Number or Rural Route Number, City or Town, State)					
TAL OR VAL DIPE 72 hours	COMPLE	29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(e) end manner as stated.												
THE HOSPI THE FUNER filed within PORTANT:		29b. SIGNATURE AND JUTLE OF CERTIFIER,				29c. LICENSE NUMBER				29d. DATE SIGNED (Month, Day, Year)				
TO THE De filed IMPOR) BE	the Happine as				26.708			1 ACT 29 1965					
	10	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JOHN WEIGER MID - PRINCE FREDERICK MID-20673												
		31, DATE FILEO (Month, Day, Year)	32. REGISTRAT'S SIGNA	ATURE O	all		VED (461	Ct	M1)-	006	13			
		OCT 3 0 1995	Jama armore	W/ - W/ U	4-4									

Amended #7, 10/25/95, MRT, Montgomery County

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	1 - STATE REGISTRAR		CERTIF	ICATE OF	DEATH	REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last) DIANNE TH	OMPSON				2. DATE OF DEATH DA	Y YEA	I K I I D	M
	The state of the s	. SEX 6. AGE (h	n yrs. leel birthdey) 51 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIFTTH (Month, Day, Year) 1 March 14, 1	944	HRTHPLACE (State or Foreign ountry)	
DIRECTOR	98. FACILITY NAME (If not institution, give street WASHINGTON ADVEN		ITAL		OR LOCATION OF DE	EATH	MONT	GOMERY	
띦	RESIDENCE OF DECEDENT 10a, STATE 10b, COUNTY		10c. CIT	Y, TOWN OR LOCA	TION			10d, INSIDE CITY	_
E I	Texas Dallas	3		Dalla	S			1 X YES 2 NO	
	10e. STREET AND NUMBER				I. ZIP CODE		10g. CITIZEN	OF WHAT COUNTRY?	
ER	9205 Chimney Corner	's			75246		U.S	S.A.	
BY FUNERAL	11. MARITAL STATUS 12 1 Never Married 2 Married 3 Widowed 4 M Divorced	2. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2 X NO	If yes, sp		NIC ORIGIN? (Specify Yee in, Puarto Rican, atc.) y:		RACE — American Indian, Black, White, etc. Specify:	
	15. DECEDENT'S EDUCATI	ion T	18e. DECEDENT'S	USUAL OCCUPATION	ON	16b, KIND OF BUS		nite RV	_
COMPLETED	(Specify only highest grade con Elementary/Secondary (0-12)		(Give kind of life. Do NOT u	work done during mo se retired.)	ost of working				
N N	12 17. FATHER'S NAME (First, Middle, Last)		Legal S	ecretary		Law ME (First, Middle, Malden	Sumama)		_
E CC	Lee Wassam				Clair				
m	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street of		Route Number, City or Tow		(•)	
5	Sterling Thompson		10723	Lake Pa	th San	Antonio, Te	xas 78	8217	
	20a. METHOD OF DISPOSITION	20b.	PLACE AND DATE	OF DISPOSITION /N	ame of	DATE 20c LO	CATION City 6	or Town, State	
	1 Burial 2 Cremation 3 Removal 4 Donation 5 Other (Specify)	M€	etery, cremetory or c etropoli	tan Crem	atory 10	/24/95A1ex	andria	,Virginia	
	21. SIGNATURE OF FUNERAL SERVICE LICENS	SEE		22. NAME A	ND ADDRESS OF FA	courv 11ins Fune			
	23. PART I. Enter the diseases, or com	Pikl		500 U	niversit	y Blvd.,W.	Sil.S	pr.,MD 20901	
-	shock, or heart fellure. List IMMEDIATE CAUSE (Final disease or condition resulting in death) a	INTRA-CEREB	ech line.	JBDURAL HE				Interval Batwee Onset and Daat	
CERTIFICATION	Sequentielly liet conditions, if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST		CONSEQUENCE O						
DICAL	PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. HISTORY OF CHRONIC CARDIAC DYSRHYTHMIA 24a. WAS AN AUTOPSY PERFORMED? 1 PES 2 NO 24b. WERE AUTOPSY FINDINGS ANALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 VES 2 NO								
2	DID TOBACCO USE CONTRIB	BUTE TO CAUSE O	F DEATH Y	ES NO [UNCERTAIL	N 🗹	-		
IAI	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEA	TH (Check only one)					_
SIC	7777	tOSPITAL: X Inpetient 2 ☐ ER/Outp	etlent 3 🗆 DOA	OTHER: 4 Nursing Hor	ne 5 🗌 Residence	6 Other (Specify)			
Y PHYSICIAN: ME	27. MANNER OF DEATH 1 Netural 5 Pending 2 Y Accident Investigation	26a. DATE OF INJURY (Month, Day, Yeer) 10-18-95		JURY W	JURY AT DRK? YES 2 X X NO	OFF OF A ST		SUBJECT FELL KING HEAD	
тер ву	2 XAccident investigation 3 Suicide 6 Could not be 4 Homicide detarmined	26e. PLACE OF INJURY building, atc. (Spec	— At home, term,	street, factory, offic	ce .	281. LOCATION (Street City or Town, Stete) DALLAS, TEX	9205 CH	IMNEY CORNER	
COMPLETED	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAL EXAMINER: 0	AN: To the best of my knowl				to the cause(a) and me	nner as stated.	use(s) and menner se stated.	
	29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUI			GNED (Month, Day, Year)	_
TO BE	Denni &	Church	NO		O.C.M			Г. 23,1995	
F	30. NAME AND ADDRESS OF PERSON WAS CHUTE	MD 1	ATH (ITEM 27) (Type 11 Pen)	n Stree	t, Balt	timore, M	iaryla	nd 21201	
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNA	_						_
	OCT 25 1995	Jalia Davidson	Rardall						
	2	ř.						DHMH-16 Rev 1	1/8

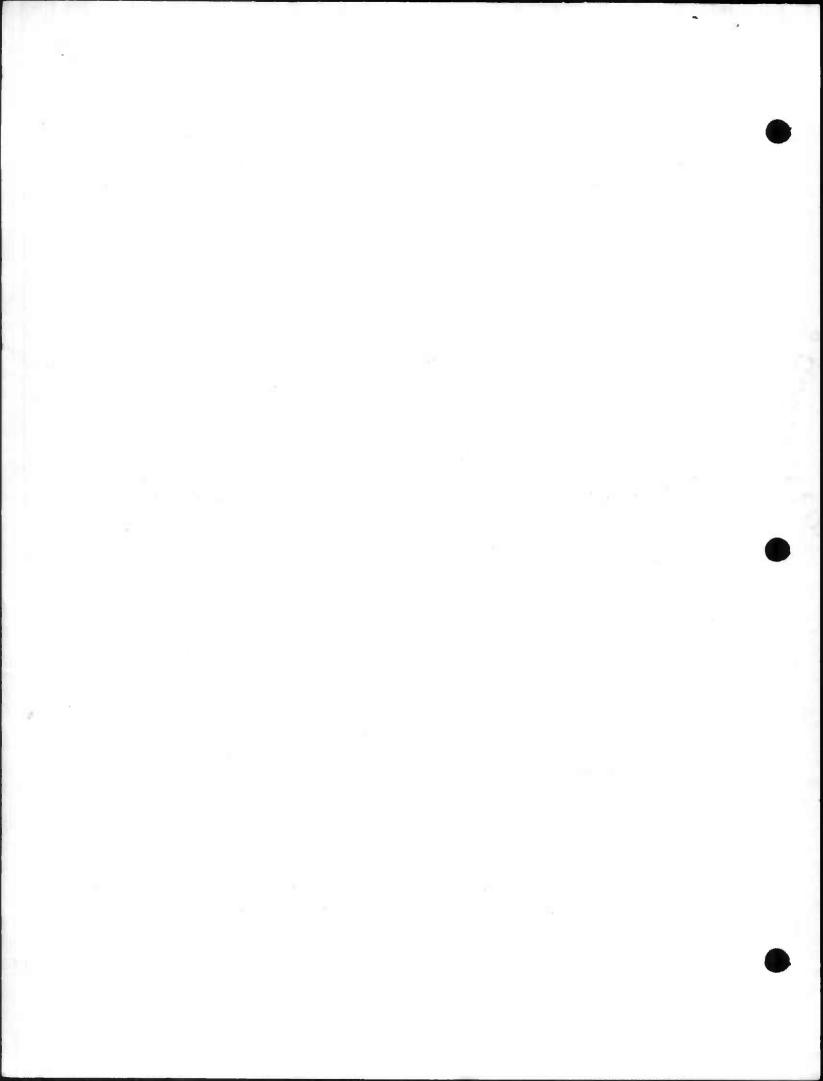
BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNEPAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlal-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlal, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

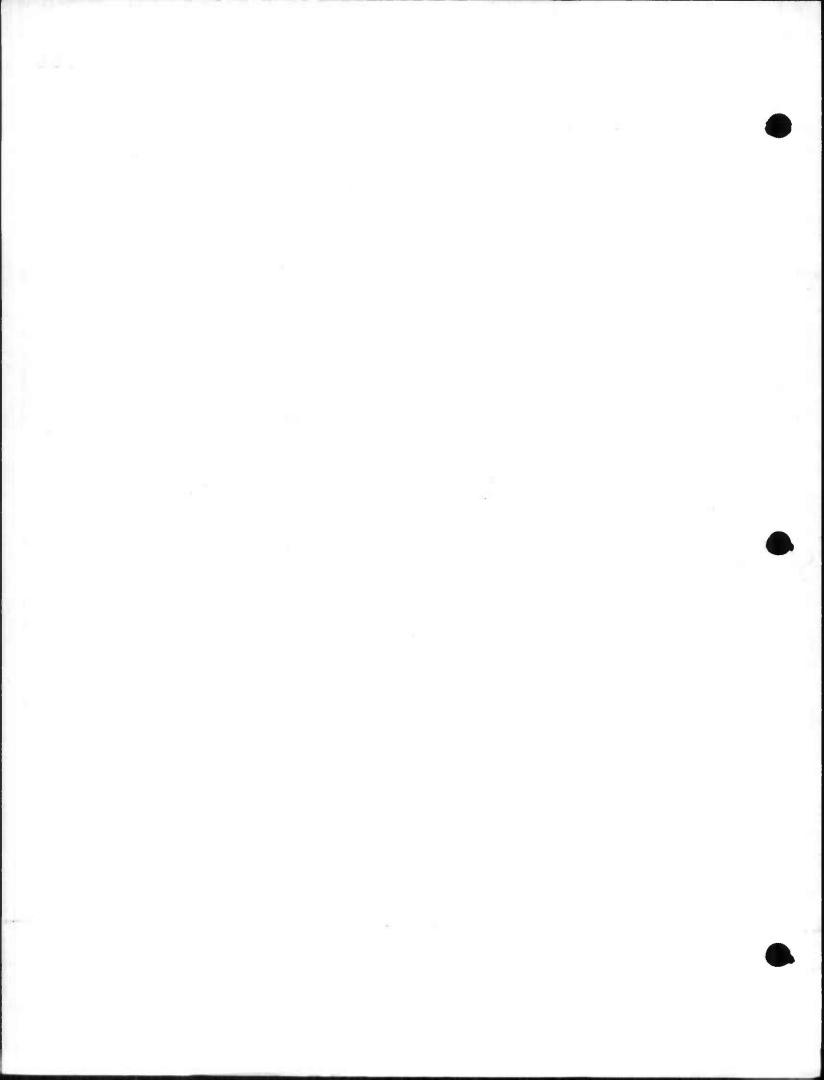
DHMH-16 Rev 1/89



Pages 1, 2, 3 should

	ermit.		
	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.		
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1	INER	thin 7	ME
10 INE MUSPIAL OR ALLENDING PRISIDENCE THE AW TEQUINES THAT THE GAME CENTIFICATE OF ENGINE CAST TOWNS AND THE MOSPIAL OF ALLENDING THE PROPERTY OF THE PRISIDENCE OF THE PROPERTY OF THE PROPE	HE FU	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunial, cremation, or removal.	IMPORTANT. If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
0	TO T	be fil	MP

	FOR 1 - STATE REGISTRAR	STATE OF MARYLAN	D / DEPAR	TMENT OF I	HEALTH AND		HYGIENE REG. NO.		
	1. DECEDENT'S NAME (First, Middle, Last)	77				2. DATE OF	DEATH		3. TIME OF DEATH
	GERALDINE	Margaret		TATH	1	МОНТН	her DAY	24 194	ET 1205 AH
		SEX 6. AGE (In y	rs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF	BIRTH		IRTHPLACE (State or Foreign
	201 10 0251		8 YRS.	MONTHS DAYS	HOURS MIN.		13,192	7 W	est Virginia
~	9a. FACILITY NAME (If not institution, give street Shady Grove Adventi				OR LOCATION OF D	EATH		9c. COUNTY (
DIRECTOR	RESIDENCE OF DECEDENT	st Hospital		Rockv:	rite			Montg	omery
E I	10a. STATE 10b. COUNTY		10c. CIT	Y, TOWN OR LOCA	TION	-			tod. INSIDE CITY
		gomery		German					t TYES 2 T NO
FUNERAL	10e. STREET AND NUMBER	3 412		10	r. ZIP CODE		- 10		OF WHAT COUNTRY?
W	20022 Frederick Roa	. WAS DECEDENT EVER IN U.	0. 4.04450	1 40 1100 000	20876				States
	1 Never Married 2 Married	FORCES? 1 YES 2	NO X	It yes, s	CENDENT OF HISPA Decify Cuban, Mexico	en, Puerto Rici			RACE — American Indian, Black, White, etc.
₩	3 Widowed 4 Divorced	IF TES, GIVE WAN ON DATE	5	I I YE	S 2 X NO Specif	ry:		_ '	Specify: White
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade com-		a. DECEDENT'S	USUAL OCCUPATI	ON ost of working	16b. KI	IND OF BUSIN	ESS/INDUST	RY
91	Elementary/Secondary (0-12)	ollege (1-4 or 5+)	life. Do NOT us	se retired.)	out or working				
MP	8	_	Wai	tress			od Ser		
	17. FATHER'S NAME (First, Middle, Laist) Edward Graham				18. MOTHER'S NA				
BE	19a. INFORMANT'S NAME (Type/Print)		195 MAIL INC	ADDRESS (Street	and Number or Rural	ssie P.			
임	Darlene Lewis								ryland 20876
	20a. METHOD OF DISPOSITION Duriel 2 Cremation 3 Removal	20b. PL					7	-	or Town, Slata
	4 □ Donation 8 □ Other (Specify)	from State cemeter.	ry, cremetory or o	therplace) Oct Memoria	lober 27, L Park	1995	Rock	ville	, Maryland
	21. SIGNATURE OF FUNERAL SERVICE LICENS			22. NAME A	ND ADDRESS OF FA	CILITY ROL	pert A	. Pum	ohrey Funeral Montgomery Ave
	+ Thinks. (-	1 Kills	M0034	Home,	'Rockvill ville, Ma	e, Ind	30	0 W. 1	Montgomery Ave
	23. PART I. Enter the diseases, or com	plicelions that ceused It	ne death. Do						
	ahock, or heart failure. List IMMEDIATE CAUSE (Finel	only one cause on each	ı ilne.						Interval Batween Onset and Death
	disease or condition reaulting in death)				421UATIO	P			10 MINUTES
_	DUE TO (OR AS A CONSEQUENCE OF):								
0 N	Sequentially list conditions, Due to (or as a consequence of):								
PAT	cause. Enter UNDERLYING DU ATER CAPDIA UND PATTY								
Ĕ	CAUSE (Disease or Injury that initiated events	DUE TO (OR AS A CO							1150
CERTIFICATION	resulting in deeth) LAST d. HIPTOPULVE CARDUS VASWUAR PLATFASE 15 Pews.								
	PART II. Other aignificent conditions of	ontributing to deeth but	not resulting	In the underlyle	ng ceuse given in	Part I. 2	4a. WAS AN AL		24b. WERE AUTOPSY FINDINGS
2	THUS POUT FOR	TIC UPLUE P	344XOOF	50 0	PEBRY		PERFORM	4	AVAILABLE PRIOR TO COMPLETION OF CAUSE
AE I						_			OF DEATH? 1 YES 2X NO
PHYSICIAN: MEDICAL	DID TOBACCO USE CONTRIB	UTE TO CAUSE OF	DEATH Y	ES NO [UNCERTAI	NIX			
S	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	OSPITAL:	PLACE DF DEA	OTHER:)				
XSI		Inpatient 2 ER/Outpatie	ent 3 🗆 DOA	4 - Nursing Ho	me 5 - Residence	Υ			
	1 Netural 5 Pending	(Month, Day, Year)	28b. TIR	JURY W	JURY AT ORK? YES 2 NO	28d. DESCR	RIBE HOW INJ	URY OCCURE	D
BY	2 Accident Investigation 3 Suicide & Could not be	28s. PLACE OF INJURY	At home, farm,			261 LOCATI	ION (Street and	i Number or B	tural Route Number.
COMPLETED	4 Homicide determined	building, atc. (Specify)					Town, State)	3 / 10/11/20/ 07 / 1	oral reside resident,
	29e. CERTIFIER 1 CERTIFYING PHYSICIAL	N: To the best of my knowled	an death come	and at the time dec	n and alone and du	. de the seven	(a) and mann		
MP	anal	on the basic of exemination s							use(s) and menner or stated.
	29b. SIGNATURE AND TITLE OF CERTIFUE				29c, LICENSE NU				BNED (Month, Day, Year)
BE	147 June	2			P 161	45	1	> oun	DEQ 27 1995
2	30. NAME AND ADDRESS OF PERSON WHO C		H (ITEM 27) (Type		-			V	
	GREGORY KOPS.	RZ ICCZ		OUE PP	· Roc	MICHE		MD	D8£0
	31. DATE FILED (MORTH, Day, 1607) OCT 27 1995 Ju	32. REGISTRAR'S SIGNATI	Lall						



TITE OR ATTENDING PHYSICIAN. The law remaines that the death certificate be executed within \$4 hours after death. Page 6 may be retained by the hospital or attending physician.	FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
THE HOSPITAL OR ATTENDING	TO THE FUNERAL DIRECTOR: After	be filed within 72 hours after death with the	IMPORTANT: If Item 28 is marked

STATE	0F	MARYLAND /	DEPARTMENT	OF I	HEALTH	AND	MENTAL	HYGIE	NE
		CE	ERTIFICATE	OF	DEAT	H		REG. N	0.

FOR STATE REGISTRAR	STATE OF MARY			OF DEA		MENTA	L HYGIENE			
1. DECEDENT'S NAME (First, Middle, Last Dorothy	Hummer Thack	ter				MONT	OF DEATH		YEAR 995	3. TIME OF DEATH 12:20 P M
4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE	(in yrs. lest birthdey)			ER 24 HRS.		OF BIRTH		8. BIRTH Countr	IPLACE (State or Foreign
578-20-3539	1 M 2 T F	79 YRS.	MONTHS	DAYS HOURS	MIN.			916		Jersey
9e. FACILITY NAME (If not institution, give	street end number)		9b. CITY,	TOWN OR LOCA	TION OF DI	EATH		9c. COUNTY OF DEATH		
259 Congressiona		Ro	ckville	2			Montgomery			
RESIDENCE OF DECEDENT	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY					10c. CITY, TOWN OR LOCATION				
								10d. INSIDE CITY LIMITS?		
Maryland Mont	Maryland Montgomery						1 [X YES 2			1 X YES 2 NO
259 Congressiona	Lane, #120			10f, ZIP CO						States
11. MARITAL STATUS	12. WAS DECEDENT EVER	IN II S ADMED	12 14	2085		NIC ORIGI	12 /Smanth: Van			STATES E — American Indian,
1 Never Merried 2 Merried 3 X Widowed 4 Divorced	FORCES? 1 YES	2X NO	11	yes, specify Cut	ben, Mexico	n, Puerto		or No.	Black	k, White, etc.
16. DECEDENT'S EI		16e. DECEDENT	S USUAL OC	CUPATION		168	. KIND OF BUS	INESS/INC	DUSTRY	
(Specify only highest gra	College (1-4 or 5 +)	(Give kind of life. Do NOT	f work done di use retired.)	uring most of work	king					
12	_	Dental	Assis	tant			Den	tal		
17. FATHER'S NAME (First, Middle, Last)		*		18. MO	THER'S NA	AME (First,	Middle, Meiden S	Sumame)		
Edward Humm	er				Pea	rl E	stelle	Wil	ls	
19e. INFORMANT'S NAME (Type/Print)		19b. MAILIN	IG ADDRESS	(Street and Numb	er or Rural	Aoute Num	ber, City or Town	, State, Zip	Code)	
George Franklin	Thacker	259 0	Congre	ssional	l Lan	ie, #	116, R	ockv.	ille	, MD 20852
20e. METHOD OF DISPOSITION	20	b. PLACE AND DATE	E OF DISPOSIT	TION (Name of	25	RAT	E 20c. LOC	ATION —	City or To	own, State
4 Donation 8 Other (Specify)	November 10m State	bb. PLACE AND DATI emetery, crematory or fontgomen								aryland
21. SIGNATURE OF FUNERAL SERVICE	LICENSEE		22. N	AME AND ADDR	ESS OF FA	ACILITY I	Robert	A. F	umph	rey Funeral
Mighele	y Xilla	MOO3		me/kock ckville						ntgomery Ave
23. PART i. Enter the diseases, o	r complications that caus				-					Approximats
shock, or heert fallur	a. List only one ceuse on									Interval Batween Onset and Death
iMMEDIATE CAUSE (Final disease or condition	Charles									1 hour
resulting in death) s. Stroke DUE TO (OR AS A CONSEQUENCE OF):								I Hour		
	Hypertensive Cardiovascular Disease 15 years									
Sequentially list conditions,										
cause, Enter UNDERLYING CAUSE (Disease or Injury	G									
that initiated events	DUE TO (OR AS	A CONSEQUENCE	OF):							
resulting in death) LAST	d									
PART II. Other algnificent conditi	one contributing to deeth	but not resulting	g in the und	derlying cause	given in	Part I.	24a. WAS AN		248	. WERE AUTOPSY FINDINGS
Arthritis	degenerative)					PERFOR			AVAILABLE PRIOR TO COMPLETION DF CAUSE
Arthritis							1 🔲 YES 😢	-Xuo		OF DEATH? 1 YES 2 NO
	TRIBLITE TO CAUSE	OF DEATH Y	/ES II N	IO EX LIN	CERTAI	ΝП				T TES 2X NO
25. WAS CASE REFERRED TO MEDICAL	1	26. PLACE OF DE			CEICIT					
DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL EXAMINER? X YES 2 \(\subseteq \text{ NO} \)	HOSPITAL:	doctions 3 DOA	OTHER	ing Home 5 X	Residence	6 🗆 Oth	er (Specify)			
27, MANNER OF DEATH	28e. DATE OF INJURY	y 28b, Ti	IME OF	28c. INJURY AT	residence		SCRIBE HOW IF	JURY OC	CURED	
1 (A) Natural 5 Pending	(Month, Day, Year)) 81	NJURY	WORK?	□ NO					
2 Accident Investigatio	28e. PLACE OF INJUI		n, street, fecto	ory, office		28f. LO	CATION (Street a	nd Numbe	r or Rural	Route Number,
- Codia not	building, stc. (Sp	oecify)				City	or Town, Stete)			
29e. CERTIFIER 1 X CERTIFYING PH	YSICIAN: To the best of my kno	owledge, death occu	irred at the til	me, date and nie	ce end du	e to the ca	use/a) and man	ner ee ste	rtad.	
and the same of th	INER: On the basis of examinat									s) end menner es steted.
CON SHOWATURE AND TYPE OF CENTER	100			200 1	ICENSE NU	MBED		204 04	TE BIGNE	D (Month, Day, Year)
X 109	MATIC	XIT								er 24, 1995
30. NAME AND ADDRESS OF PERSON	WHO COMPLETED CARRE OF I	DEATH (ITEM 27) (54	ne Print)		0747	Τ				
Paul T. Noone, I				e, #207	, Ro	ckvi	lle, Ma	rvla	and	20852
31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIG	GNATURE		,	,		,	1		
OCT 25 199	5 Julia Davides	or Randall								
A	0									DHMH-18 Rev 1/81

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S	H	-
DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by it	WRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be	-
S. A.	REC	-
6	憲	1

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR! After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be find within 72 hours after death with the State Dent, of Health and Mental Hopiene prior to burial, cremation, or removal.	0
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TO BE COMPLETED BY FUNERAL DIRECTOR

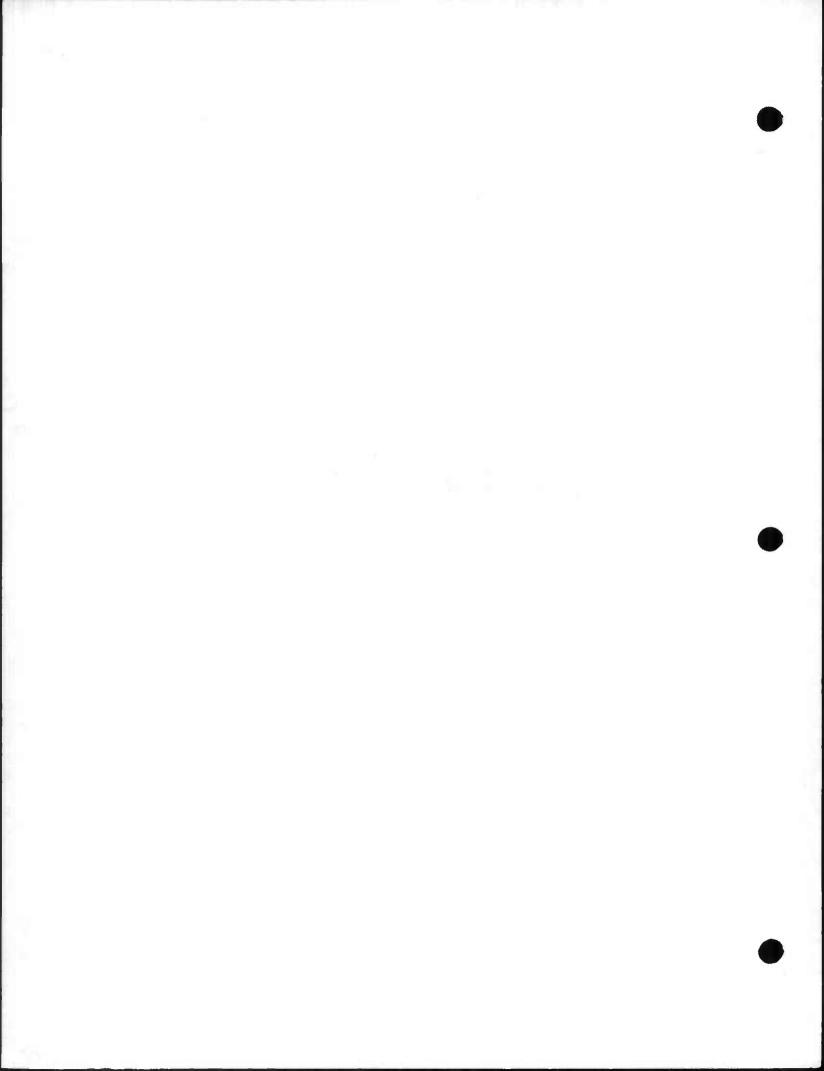
FOR STATE REGISTRAR		STATE OF MARY		MENT OF H		MENTA	HYGIEN REG. NO.	E	
1. DECEDENT'S NAME (First, Charles Wat		ompson					OF DEATH	3, 1995	3. TIME OF DEATH 9:30A
4. SOCIAL SECURITY HUMB		-	(In yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7 DATE	OF BIRTH	8.8	BIRTHPLACE (State or Foreign
577-50-8802		M 2 F	80 YRS.	MONTHS DAYS	HOURS MIN.	_	e 30,	1915 Wa	ashington, D
7906 Rivers	ide Dri			Cabin		EAIN			gomery
100. STATE Maryland	Montgo	omerv		in John					10d. IHSIDE CITY LIMITS?
10e. STREET AHD HUMBER	попевс	Jine Ly	000		ZIP CODE	_		10g. CITIZEH	OF WHAT COUHTRY?
7906 Rivers	side Dri	ive			20818			United	d States
11. MARITAL STATUS 1 Hever Married 2 X 3 Wildowed 4 Divok	Married med	2. WAS DECEDENT EVER FORCES? 1 X YES IF YES, GIVE WAR OR World War	S 2 HO DATES	If yes, sp	ENDENT OF HISPA ecity Cuban, Maxics 2 X XNO Specifi	an, Puerto I			RACE — American Indien, Black, White, atc. Specify: White
(Specify only	EDENT'S EDUCAT	TION mpleted)	16a. DECEDENT'S L	ork done during mo		16b	KIND OF BU	SIHESS/INDUST	TRY
Elementary/Secondary (D	-12)	College (1-4 or 5+) 5+	Physici	an			Intern	al Med	icine
17. FATHER'S HAME (First, Mi	iddle, Last)	<u> </u>	111/0202		16. MOTHER'S HA				
J. Lawn Tho	ompson				Anna	Wate	rs		
19a. INFORMANT'S NAME (7)			196. MAILINO	AOORESS (Street a	and Number or Rural	Route Num	ber, City or Tow	n, Stata, Zip Coo	de)
Charles Wat	ers The	ompson, Jr	. 7906 R	liversid	e Drive,	Cab	in Joh	n, Mar	yland 20818
20a. METHOD OF DISPOSITI 1 Burial 2 Crematio 4 Donation 5 Other	n 3 🗆 Ramova	al from State	ob. PLACE AHDDATE Of the second control of t	FDISPOSITION (Note place) Octo	ber 25,	1995	E 20c. LO	CATION — City	or Town, State le, Maryland
21. SIGNATURE OF FUNERAL	L SERVICE LICEN	SEE	10110000	22. HAME A	NO ADDRESS OF FA	KCILITY R	obert	A. Pum	phrey Funera
* Kai	IE.	em.	M00803	Home/ Wisco	Bethesda nsin_Ave	-Che	vy Cha Bethe	se, In	c. 7557 aryland 208
23. PART I. Enter the di ahock, or hi		nplications that cause on		ot enter the mo	de of dying, euc	ch ee can	diec or reep	iratory arrest,	Approximete Interval Between
IMMEDIATE CAUSE (Fin	al								Onset and De
disease or condition resulting in deeth)	→ a	Prostate							15 Mont
		DUE TO (OR AS	A CONSEQUENCE OF):					
Sequentially list conditions in any, leading to immediate	diata	DUE TO (OR AS	A CONSEQUENCE OF):					
cause. Enter UNDERLY! CAUSE (Disease or Injuthat initiated events resulting in death) LAS	ry C.	OUE TO (OR AS	A CONSEQUENCE OF):					
PART II. Other eignifica	nt conditions	contributing to deeth	but not reaulting in	n the underlyin	g ceuse given in	Pert i.	24a. WAS AN		24b. WERE AUTOPSY FINDIN
							PERFOI		AVAILABLE PRIOR TO COMPLETION OF CAUSI OF DEATH? 1 YES 2 NO
DID TOBACCO U	SE CONTRI	BUTE TO CAUSE	OF DEATH YES	S D NO K	k uncertai	NΠ			1 1 123 2
25. WAS CASE REFERRED TO EXAMINER?	O MEDICAL	HOSPITAL:	26. PLACE OF DEATI	H (Check only one) OTHER:					
1 YES 2 HO	1	28a, DATE OF INJUR			JURY AT			HJURY OCCUR	ED
1 Netural 5	Pending Investigation	(Month, Day, Year		URY W	ORK? YES 2 NO	280. DE	SCHIBE HOW	NJUHY OCCUR	ieo
3 Suicide 6	Could not be detarmined	28s. PLACE OF INJU building, etc. (S	RY — At home, ferm, a pecify)	treet, factory, offic	ta .		CATION (Street or Town, State		Rurel Route Number,
Crieck orny		AN: To the best of my kn							suse(s) and manner as stated
250. BIGHATUNE AND TOTAL	of CERTIFIE	de			29c. LICENSE NU	MBER		29d. DATE SI	IONED (Month, Day, Year)
SO. NAME AND ADDRESS OF	PERSON WILD	SOMPLE PER CALISE OF	OFATH (ITEM 27) /3ma	Print)	DC5244				ober 24, 199
Harold S. M	Mirsky,	м.6. 730	24th Stre		., #7, W	<i>l</i> ashi	ngton,	D.C.	20037
DCT 2	5 1995	HEGISTRAR'S, SI	ox lardall						

BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or ramoval.

FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

-		REGISTRAR		CERTIF	CATE O	F DEATH	REG. NO		
- 1		1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH
- 1		FLOSSIE LEE VERNO	N				MONTH DA	YEAT 95	
- 1		4. SOCIAL SECURITY NUMBER 5.	SEX 6. AGE (in yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH		TTHPLACE (State or Foreign
		230-54-3203	A PARTY NAMED IN COLUMN	8 YRS.	MONTHS DAYS		(Month Day Year)	Con	untry)
- 1		9a. FACILITY NAME (If not institution, give street							
	~					OR LOCATION OF D	EATH	9c. COUNTY OF	
	DIRECTOR	Waterview Health Ca	are Center		Salis	oury		Wi	comico
	ည္မ	10a. STATE 10b. COUNTY		100 0173	, TOWN OR LO	ATION			
	<u>E</u>	Md. Wicomio							10d. INSIDE CITY LIMITS?
				Sa	lisbury				XX YES 2 NO
-1	₹	10e. STREET AND NUMBER				101. ZIP CODE		10g. CITIZEN O	F WHAT COUNTRY?
	FUNERAL	1028 Pemberton Dr.	Apt. #3			21801		USA	
- 1	5		. WAS DECEDENT EVER IN FORCES? 1 YES	U.S. ARMED	13. WAS D	ECENDENT OF HISPA	NIC ORIGIN? (Specify Yes	or No- 14. R/	ACE — American Indian,
	PY	1 Never Married 2 Married 3XX Wildowed 4 Divorced	IF YES, GIVE WAR OR DA			epecify Cuban, Maxica ES 3/13/ NO Specific		1	eck, White, etc.
		3/A widowed 4 Divorced							White
	8	15. DECEDENT'S EDUCATI (Specify only highest grade con		16a. DECEDENT'S	rork done durina	TION most of working	16b. KIND OF BU	SINESS/INDUSTRY	
	Ш	Elementary/Secondary (0-12)	College (1-4 or 5 +)	life. Do NOT us	e retired.)				
	P P	7		Homemak	er		Home		
8	COMPLET	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Middle, Maiden	Sumame)	
#	ш	George Henry Landis	S			Amanda	a Bowman La	andis	
<u></u>	B	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street	t and Number or Rural	Route Number, City or Tow	n, State, Zip Code)	
ם	2	Betty L. El Sadr					Apt. 3 Sal:		
8	- 1	20a. METHOD OF DISPOSITION	20b	PLACE AND DATE O			DATE 20c. LO		
100		1 Donation 5 Other (Specify)	from State cem	etery, crematory or oti	her place!				
5		21. SIGNATURE OF FUNERAL SERVICE LICENS	SEE //	mbridge		AND ADDRESS OF FA	10-13 Car	indi idge,	Mu.
examiner must be notified at once.		N 111 200	111,	/			Home, Inc.		
8		William M.	Hot				t. Delmar,		040
2 F		23. PART I. Enter the diseases, or com	plications that caused	the death. Do n	ot anter the r	node of dyling, suc	h as cardiac or reapi	ratory arrest,	Approximate
Ē		shock, or heart failure. List IMMEDIATE CAUSE (Final	t only one cause on as	ach line.					Interval Between Onset and Death
흩		disease or condition	cougestru	o LIPE	PT FA	111.25			
ent,	l	resulting in death) a		CONSEQUENCE OF		1496			7570
8	_			OSTIGLACIAN OF	,-				
or other traumatic event, the medical	RTIFICATION	Sequentially list conditions, b	DUF TO (OR AS A	CONSEQUENCE OF	١٠				
Ē	¥	If any, leading to immediate cause. Enter UNDERLYING			,.				
5	윤	CAUSE (Disease or Injury C	DUE TO (OR AS A	CONSEQUENCE OF	١٠				
8	Ē	that initiated events resulting in death) LAST			,-				i i
, ,	CE	d							<u> </u>
흗		PART II. Other algnificant conditions of	ontributing to death be	ut not resulting in	n the underly	ing cause given in	Part I. 24s. WAS AN		46. WERE AUTOPSY FINDINGS
2	DICAL						PERFOR	IMED?	AMAILABLE PRIOR TO COMPLETION OF CAUSE
2	LLL III						1 [] YES 2	NO NO	OF DEATH?
	Σ	DID TODA CCO LICE COLUMNIA							1 TYES 2 NO
23	Ž.	DID TOBACCO USE CONTRIB					N 🗆 📗		
or Item	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	OSPITAL:	26. PLACE OF DEAT	OTHER:	e)			
5	YSI		☐ Inpetient 2 ☐ ER/Outp	atient 3 🗆 DOA		ome 5 🗆 Residence	8 Other (Specify)		
ed,	표	27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME	OF 28c. I	NJURY AT VORK?	28d. DESCRIBE HOW I	NJURY OCCURED	
	B	1 Netural 5 Pending Investigation				YES 2 NO			
99		3 Suicide 6 Could not be	28s. PLACE OF INJURY building, atc. (Spec	— At home, farm, at	treet, factory, of	lice	281, LOCATION (Street a	and Number or Run	al Route Number,
500	쁘	4 Hornicide determined					City or Town, State)		
E	COMPLET	290. CERTIFIER CERTIFYING PHYSICIAN	N: To the heat of my knowl	adaa daath aasuuu	d at the time of				
	불	(Check only one) 2 MEDICAL EXAMINER: 0	N: To the best of my knowl						
	8		THE STATE OF GRAININGTON	- Investigation	i, in my opinion	death occurse at the	time, data and place, an	d que to the caus	e(s) and manner as stated.
통	8	29b. SIGNATURE AND TITLE/OF CERTIFIER				29c. LICENSE NUI		29d. DATE SIGN	ED (Month, Day, Year)
	0	ualus Me	- MD			1032	014	► 10/13	191
	F	30. NAME AND ADDRESS OF PERSON WHO CO	OMPLETED CAUSE OF DEA	ATH (ITEM 27) (Type,	Print)				
		MAHESY MOONIX	e4 547	E Run	EVSI'DI	Dini	, Sausky	RYM	p 21801
		31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNA	ATURE			1/19	. /	,
			1						



DHMH-16 Rev 1/89

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

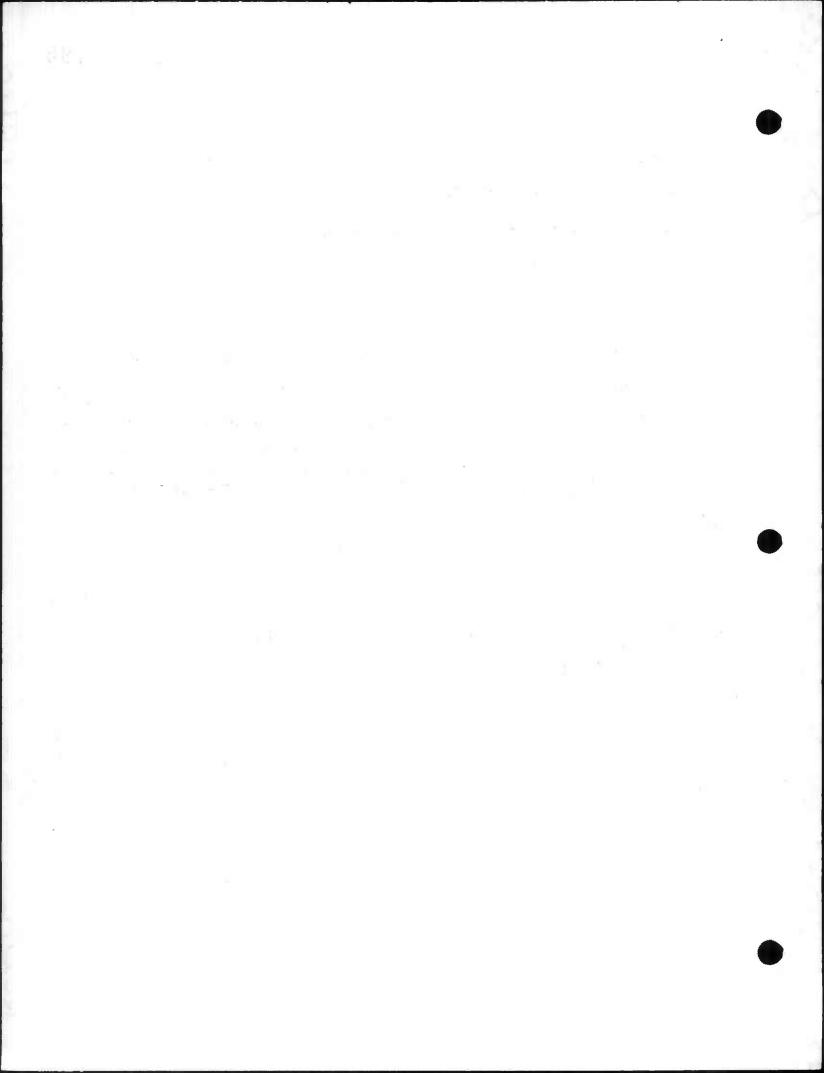
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should be filled within 27 bunial and Mental Hygiens provide by the contraction or removal.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

			D / DEPARTMENT O	 MENTAL	HACIENE
# /, 10/31/95, MRT, Montgomery County				 AACMTA.	

_	REGISTRAR CERTIFICATE OF DEATH REG. NO.								
	1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH								
	1005000 VO ratt 100000000000000000000000000000000000								
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 2 CHRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign								
	050_18_1/19 1974M 2 F 72 YRS. MONTHS DAYS HOURS MINI. (Month, Day, Vear) Country)								
	Se. FACILITY NAME (If not institution the street and number)								
Œ	CHADE CHOUSE ADVISOR ADVISOR AND ADVISOR ADVIS								
16	SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE MONTGOMERY								
DIRECTOR	10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY								
E	MADVI AND MONTGOMERY								
	OFFICE AND WHIPPE								
FUNERAL	10. AP CODE 10g. CITIZEN OF WHAT COUNTRY?								
H	183 LAZY HOLLOW DRIVE 20878 UNITED STATES								
5	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 1 Never Merried 2 Married 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea or No— Black, White, etc.) 14. RACE — American Indien, Black, White, etc.								
ĕ	3 \(\) Widowed 4 \(\) Divorced \(\) Divorced \(\) F YES, GIVE WAR OR DATES \(\) 1 \(\) YES ZYNO Specify: Specify:								
	WHILE								
H	(Specify only highest grade completed) (Give kind of work done during most of working								
"	Elementery/Secondary (0-12) College (1-4 or 5+) life. Do NOT use retired.)								
E E	12 FIRE CHIEF DISTRICT GOVERNMENT								
COMPLETED	17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Malden Surname)								
5 111	DAVID VAROFF BESSIE SHAPIRO								
TO B	19e. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code)								
	MARGARET VAROFF 183 LAZY HOLLOW DRIVE-GAITHERSBURG, MD, 20878								
200	20e. METHOD OF DISPOSITION								
3	1 Burtel 2 X Crematton 3 Removal from State 4 Donatton 5 Other (Specify) Company or other place) MT. COMFORT 10-26 ALEXANDRIA, VIRGINIA								
	DANZANSKI-GOLDBERG MEMORIAL CHAPELS, INC.								
	1170 ROCKVILLE PIKE-ROCKVILLE, MD 20878								
	23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest,								
	snock, or hasn silve. List only one cause on aech lina.								
	IMMEDIATE CAUSE (Final disease or condition								
and the same of th	resulting in death) a. Cavdiac avrest DUE TO (OR AS A CONSEQUENCE OF):								
ATION	Sequentially list conditions, Due To/(OR AS A CONSEQUENCE OF): Due To/(OR AS A CONSEQUENCE OF):								
F	arry, reading to minimonate								
2	CAUSE (Disease or Injury C. LINGE 1004) LEDOVOTONIY 100015								
TIFIC									
CERTIFICATION	resulting in deeth) LAST d. Adeno carcinoma gall bladder								
	PART II. Other significent conditions contributing to deeth but not resulting in the underlying ceuse given in Part i. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS								
DICAL	PERFORMED? AMAILABLE PRIOR TO COMMITTEE OF THE PRIOR TO COMMITTEE OF THE PERFORMENT								
	1 U YES 2 NO COMPLETION OF CAUSE OF DEATH?								
M	1 U YES 2 NO								
PHYSICIAN: ME	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN								
SICIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 28. PLACE OF DEATH (Check only one)								
YSIC	HOSPITAL: 1 VES 2 NO HOSPITAL: 1 Inpatient 2 ER/Outpetient 3 DOA 4 Nursing Nome 5 Residence 6 Other (Specify)								
<u> </u>	27. MANNER OF DEATH 286. DATE OF INJURY 286. TIME OF 286. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED								
	1 Naturel 5 Pending (Morat, Day, 1997) INJURY WORK? M 1 VES 2 NO								
	2 Accident Secretary Constitution of the PLACE OF INJURY At home form strend fundamental and an accident secretary constitution of the Constitutio								
9	5 Suincide 6 Could not be building, etc. (Specify) 4 Homicide determined building, etc. (Specify)								
LET	20°. CERTIFIER V								
P M	(Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) and manner ea stated.								
COMPLETED	one) 2 MEDICAL EXAMINER: On the basic of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(e) and manner ea stated.								
SE COI	29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)								
	1 7 7 7								
2	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Typa, Print)								
	Diati For A. A. OTIF hardis ACab D. Rack illa had								
	Robert L. Fox, M.D. 9715 Medical Center Drive, Rockville, Md.								
	31. DATE FILED (Month-Day, Year) 32. REGISTRAR'S SIGNATURE								
	OCT 26 1995 Julia Stevelson Rendall								



BALTIMORE, MARYLAND 21215-0020

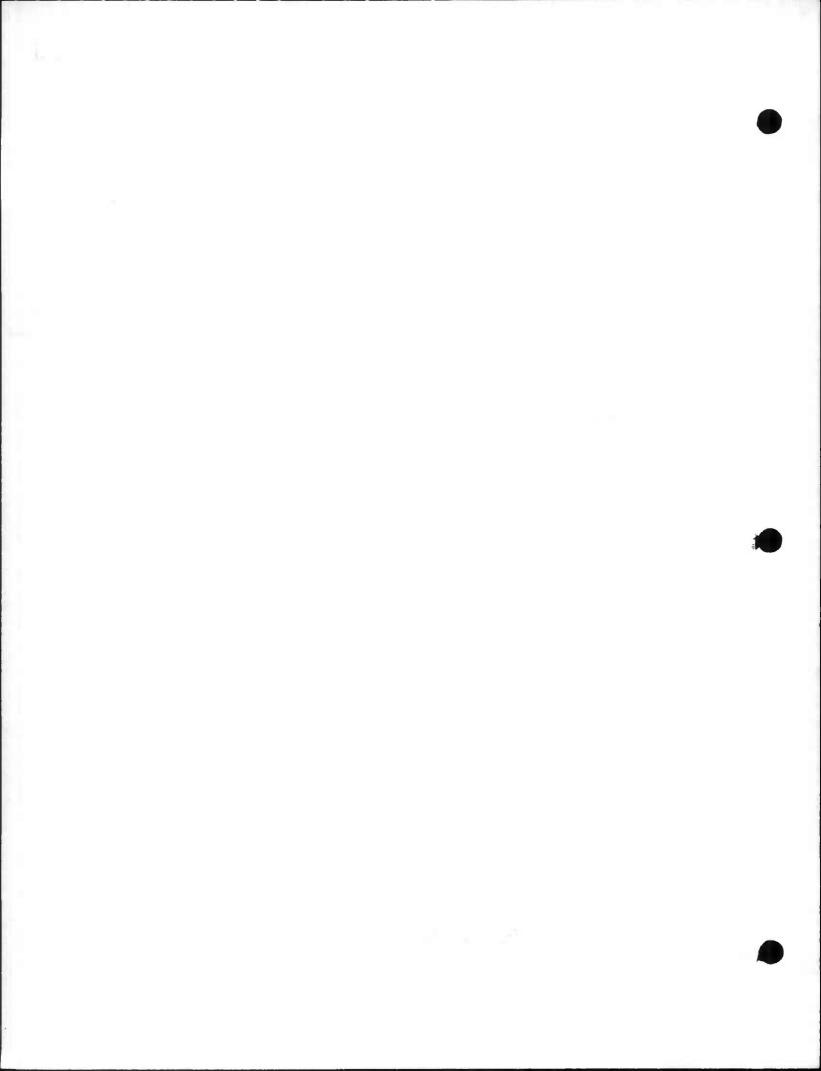
DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with a hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

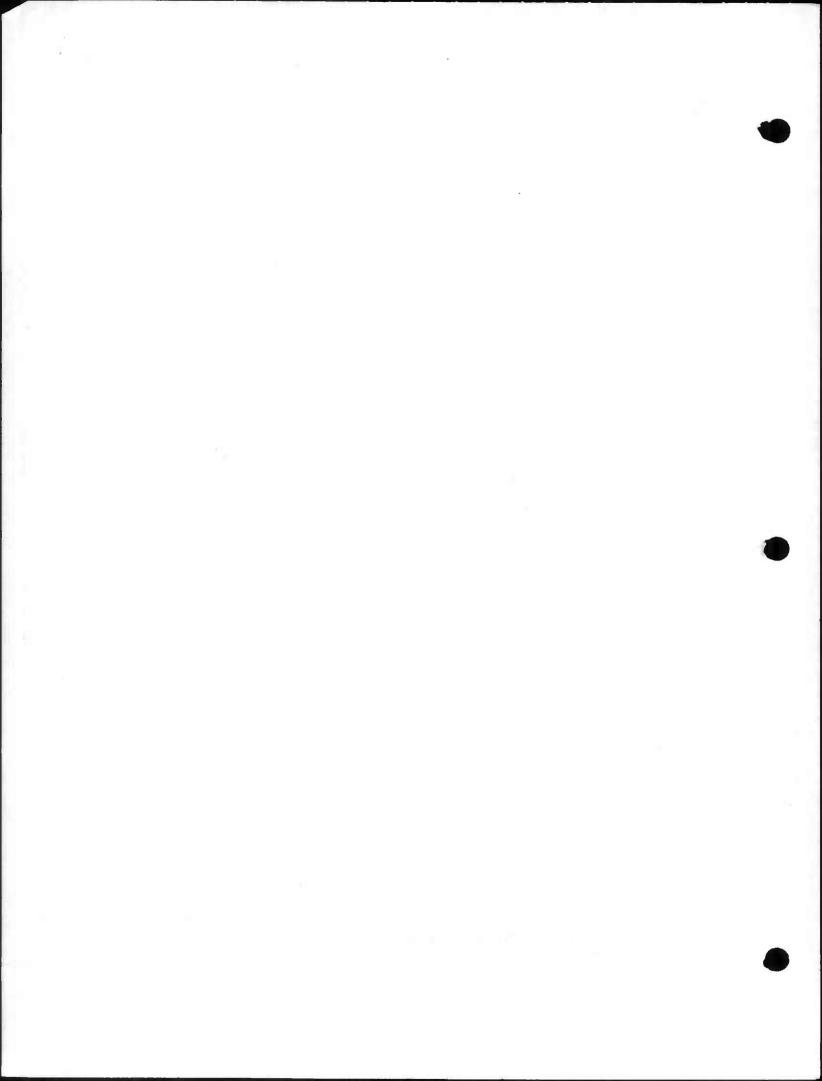
IMPORTANT: If them 28 is marked, or them 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

3. TIME OF DEATH
7 1995 1150 M
BIRTHRI ACE /Close or Familia
18 Maryland
9c. COUNTY OF DEATH
WICOMICO
10d. INSIDE CITY
1 VES 2X NO
10g. CITIZEN OF WHAT COUNTRY?
USA
or No- 14. RACE — American Indian, Black, White, etc.
Specify:
African American
enter
Surname)
, State, Zip Code) Maryland 21856
ATION — City or Town, State
ipquin, Maryland
Memorial Chapel
ry, Maryland 21801
atory arreat, Approximate
interval Between Onset and Death
702
MED? 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE
OF DEATH?
1 TYES 2 NO
JURY OCCURED
JURY OCCURED
JURY OCCURED Id Number or Rural Route Number,
od Number or Rural Route Number,
ed Number or Rural Routa Number, ver as stated.
od Number or Rural Route Number,
ed Number or Rural Routa Number,
od Number or Rural Route Number, her as stated, due to the cause(s) and manner as stated.
ord Number or Rural Route Number, her as stated. due to the cause(s) and manner as stated. 29d, DATE SIGNED (Month, Day, Year)
od Number or Rural Route Number, her as stated. due to the cause(s) and manner as stated. 29d. DATE SIGNED (Month, Day, Year)



		1 - FOR STATE REGISTRAR	STATE OF MARY	LAND / DEPA	RTMENT OF	HEALTH AND	MENTAL	HYGIENE REG. NO.			
	8	1. DECEDENT'S NAME (First, Middle, La	DECEDENT'S NAME (First, Middle, Last)							3. 1	TIME OF DEATH
	8	Kathleen R					Oct	. 16 DAY	199	D D	93m "
Pir		4. SOCIAL SECURITY NUMBER 219-05-3448	1 M 2 NF	E (In yrs. lest birthday) 73 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.		F BIRTH Day, Year)		Country)	CE (State or Foreign
2, 3 should	CTOR	84. FACILITY NAME (II not institution, given the property of t	Ave.			OR LOCATION OF D	EATH		9c. COUNTY	OF DEATH	
pes 1	ш	RESIDENCE OF DECEDENT 10e. STATE 10b. COL		10c. Cl	TY, TOWN OR LOCA	ATION				10d	. INSIDE CITY
permit. Pages	AL DIR	Maryland Wic	comico		Salisbury				10g. CITIZEN	1 [LIMITS? YES 2 NO
1st	E I	707 Richmond	Ave.			21801			U.S		COUNTRIT
020 physician. burlal-transit	FUN	11. MARITAL STATUS	12. WAS DECEOENT EVER FORCES? 1 YE	IN U.S. ARMED	13. WAS DE	CENDENT OF HISPA	NIC ORIGIN?	(Specify Yes o			American Indian,
21215-0020 al or attending physician for use as the burlal-tra	BY	1 Never Married 2 Married 3 Wildowed 4 Divorced	IF YES, GIVE WAR OR			S 2 NO Specific		cen, etc.)		Specify:	Re, etc.
ttendii	0	15. OECEDENT'S I	EDUCATION	16a. OECEDENT'S	USUAL OCCUPAT	ION	165 1	CIND OF BUSIN	VESS/INDITES		lack
E 8 3	E	(Specify only highest gi	College (1-4 or 5+)	(Give kind of life. Do NOT o	work done during m	nost of working	100.7	and or boom	1000/11000		
AND 2 the hospital detached to	COMPLET	12		Dome	stic			None			
YLAN by the ho be detach at once.		17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA			mame)		
	B	Herman Rhock 19a. INFORMANT'S NAME (Type/Print)		105 MAII IN	ADDRESS (See	Netti and Number or Rural					
	2	Larry White	SR .			nd Ave.					1
RE, may be x, page		20a, METHOD OF DISPOSITION	2	Db. PLACE AND OATE	OF DISPOSITION /A		DATE	20c. LOCA	TION — City		
BALTIMOR er death. Page 6 may the funeral director, p val.	1	1 Surial 2 Cremation 3 R 4 Donation 5 Other (Specify)		Green A			10/21	Sa1	isbur	cv.M	d.
ALTIN death. Pag e funeral di J. examiner	į	21. SIGNATURE OF FUNERAL SERVICE				AND ADDRESS OF FA					
BALTIMOF after death. Page 6 m by the funeral director, moval.			B. Stewa		821 1	art Fun West Rd	.Sal	isbur	v.Md.	. 218	01
n by		23. PART i. Enter the diseases, shock, or heart fellu	or complications that caus re. List only one cause on	ed the deeth. Do	not enter the m	ode of dying, suc	h aa cardi	oc or reapira	tory arrest,		Approximate Interval Between
24 TE OF TE		IMMEDIATE CAUSE (Fine)								Onset and Death	
5 5 8	- 1										MINS
8 6 7 6	_		Status Post MT MANS								
NA 8 OF	CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO JOR AS	A CONSEQUENCE C	OF):						
0 8 E 2 P	CA	CAUSE (Disease or injury	a #3(VI							YRS
O 12 28 5	Ē	that initiated events resulting in death) LAST	DUE TO (ON AS	A CONSEQUENCE O	PF):						
the death of Mental H			d								
T = 05 -	EDICAL	PART ii. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part i. 24s. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO							AWAI	E AUTOPSY FINDINGS LABLE PRIOR TO IPLETION OF CAUSE DEATH?	
w requires the been signed pr. of Health a shows any	≥						_			1 🗆	YES 2 NO
AL F has be Dept.	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL	. T		26.0	N ACE OF DEATH (C)	vack and and				
는 문 음 등	SIC	EXAMINER?	HOSPITAL:	tostlent 3 🗆 DOA	OTHER:	me 5 Hesidence					
PHYSICIAN: this certification with the Structure or It	¥	27. MANNER OF OEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. Til	ME OF 28c. IN	JURY AT		RIBE HOW INJ	URY OCCURE	ED	
	BY	1 Natural 5 Pending 2 Accident Investigation		- 12		ORK? YES 2 NO					
TTENDI TTOR: A after d	ETED !	3 Suicide 8 Could not 4 Homicide determined		RY — At home, farm, ecify)	street, factory, offic	CO .		ION (Street and Town, State)	l Number or R	tural Route	Number,
DIV AL OR A AL DIREC 72 hours If Item	2	29e. CERTIFIER (Check only	YSICIAN: To the best of my kno	wledge, death occur	red at the time, date	e and place, and due	to the cause	e(a) and manne	or as stated.		
HOSPITAL FUNERAL within 72 t	COMPL	one) 2 MEDICAL EXAM	INER: On the beels of examinat	on and/or investigati	on, in my opinion,	death occured at the	time, data a	nd place, and	due to the ce	use(a) and	manner as stated.
TO THE HOSPITAL TO THE FUNERAL De filed within 72 IMPORTANT: II	H	29b. SIGNATURE AND TITLE OF CERTI	FIER /			29c. LICENSE NUI		2	Pd. DATE BIO	GNED (Mon	th, Day, Year)
228	ဥ	30. NAME AND ADDRESS OF PERSON	my comp	m	0.00	0106	88		10	117	18/
		DONALD M.	Wood Me	5	a, Print)						
5		OCT 1 8 199	5 July Davids	NATURE CU-RON-11				· ·			
		00110133	J Martin	- me College							

	FOR STATE REGISTRAR	STATE OF N		DEPAR					MENTA	L HYGIENI	E		
	1. DECEDENT'S NAME (First, Middle, Las	t)								OF DEATH		YEAR	3. TIME OF DEATH
	ANDRE				WINI	DER	DER OCTOBER			BER T	14,1	995	3:35 P.M
	4. SOCIAL SECURITY NUMBER	5. SEX	8. AGE (In yrs. le		IF UNDER	1 YEAR DAYS	IF UNDER	24 HRS.	7. DATE (Mont	OF BIRTH h, Day, Year)		8. BIRTHE Country	PLACE (State or Foreign
	220-84-1538	1 X M 2 □ F	20	YRS.					Sept	. 4,19			MD
œ	9e. FACILITY NAME (If not institution, give		_				R LOCATIO		ATH			TY OF DE	
DIRECTOR	409 E.ELIZABE	TH STREE	T		SA.	LISI	BURY				MIC	OMIC	.0
Ä	10s. STATE 10b. COUR	NTY		10c. CIT	Y, TOWN O	R LOCAT	ION						10d. INSIDE CITY LIMITS?
		Wicomico			Sali	isbu					1 XYES 2 NO		
FUNERAL	10e. STREET AND NUMBER	1 61				101.	ZIP CODE						HAT COUNTRY?
INE	409 E. Elizabet	h St.	T EVED IN II S. AI	BMEN	13.1	MAS DECI		801	IIC OBIGII	i? (Specify Yea			States - American Indian.
	1 X Never Merried 2 Merried	FORCES? 1	YES 24	NO	1	t yes, spe		n, Mexice	n, Puerto	Ricen, atc.)	or No-	Black, Specifi	White, etc.
ВУ	3 Widowed 4 Divorced		AIT OIT DATES			1 163	2 22 110	Specify	·.			Specify	Black
COMPLETED	15. DECEDENT'S EI (Specify only highest gre	DUCATION ide completed)	(0	ECEDENT'S Give kind of	work done o			g	168	. KIND OF BUS	INESS/IND	USTRY	
<u>=</u>	Elementery/Secondery (0-12)	College (1-4 or 5 +	·) ///	a. Do NOT u		_						/-	
ME	10th grade 17. FATHER'S NAME (First, Middle, Last)				n/a	2	18 MOTE	AFD'S NA	ME /Eirot	Middle, Meiden	n/	d	
	Howard E. Wind	er								. Dutt			
BE	19e. INFORMANT'S NAME (Type/Print)		11	9b. MAILING	ADDRESS	(Street a				ber, City or Town		Code)	
5	Sharon D. Bradle	У	4	409 E	. El:	izab	eth :	st.,	Sal	isbury	, MD	2180	01
	20e. METHOD OF DISPOSITION 1 X Buriel 2 Cremetion 3 Re	emoval from State	20b. PLACE cemetery, cr Greet	AND DATE	OF DISPOS	ITION /Na	me of	D l -		20c. LO	CATION — (vn, State
	4 Donetion 5 Other (Specify) 21, SIGNATURE OF FUNERAL SHIPPICE	Vicennes	Green	n Acr	_	_	1al			ZII Sa	lisbu	ıry	
	5	_/_	_]	Lewi	s N.	Wat	son	Funera			
		- 1											MD 21801
	23. PART I. Enter the diseases, o shock, or heart fallur	e. Liet only one ceu	ise on eech lin	ie.	101 enter	the mo	de of dyl	ng, suc	h ae car	diac or respi	ratory arr	D-61,	Approximata interval Between
	IMMEDIATE CAUSE (Finel disease or condition	~		-	FT	~	-1	- 0	•				Onset and Death
	resulting in death)	DUE 10	(OR AS A CONSE	EQUED CIE O	V C	101	~	~>	Y 3				
Z	Sequentially liet conditions,	m b	-										
ATIO	If any, leading to immediate cause. Enter UNDERLYING	DUE TO	(OR AS A CONSE	EOUENCE O	F):								
FIC/	CAUSE (Disease or Injury that initiated events	c. DUE TO	(OR AS A CONSE	EQUENCE O	F):								
CERTIFICATION	resulting in death) LAST	4											
	PART II Other plentilisent conditi	lone contribution to	alcath hut mat		In the con	al a al al a a		6.000001	Dia I				
CAL	PART II. Other algnificant conditi	one contributing to	deeth out not	reauting	in the un	ideriying	g cause o	given in	Part I.	24s. WAS AN PERFOR	MED?	246.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE
MEDIC									_	1 YES 2	□ NO		OF DEATH?
Σ	DID TOBACCO USE CON	STRIBUTE TO CA	USE OF DEA	ATH YI	S 🗆 I	NO E	LUNC	ERTAII	ПΝ				YES 2 NO
IAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?			CE OF DEA									
SIC	1X XYES 2 □ NO	HOSPITAL:	ER/Outpatient	3 🗆 DOA	OTHER		• XXR	eldence	8 🗆 Oth	er (Specify)			
PHYSICIAN:	27. MANNER OF DEATH Netural 5 Pending	28e. DATE OF (Month, D		28b. TIN	IE OF JURY	28c. INJ WO	RK?		28d. DE	SCRIBE HOW I	NJURY OCC	URED	
BY	2 Accident Investigation		NE IN RIPLY AA N		M	1 🗆 1		NO		awana on .			
ED	3 Suicide 8 Could not it	building,	of INJURY — At h etc. (Specify)	iome, rarm,	street, tect	ory, ome	•			or Town, Stete)		or Hural H	oute Number,
E	29e. CERTIFIER 1 CERTIFYING PH	YSICIAN: To the best of	my knowledge d	feeth occur	ad at the t	lma data	and plans	and due	to the se	uan(a) and mas	anna an atat	4	
COMPLET	one)	THE On the basis of e											end menner es steted.
	29b. SIGNATURE AND TITLE OF CERTIFICATION	men.					29c. LICI	ENSE NUI	MBER		29d. DATE	SIGNED	(Month, Day, Yeer)
BE		XX	~			1	0.	C.M	1.E.		осто	BER	15,1995
٥	30. NAME AND ANDRESS OF PERSON	WHO COMPLETED CAU	SE OF DEATH (IT	ЕМ 27) (Туре	, Print)						3310		,
	M	Ken	11	11 Pe	enn	Str	eet,	, Ba	alti	more,	Mar	yla	nd 21201
	OCT 1 7 19	95 Jalia	AND SIGNATURE	04-11									
	0011119	33 1 June 1							-				DHMH-16 Rev 1/8



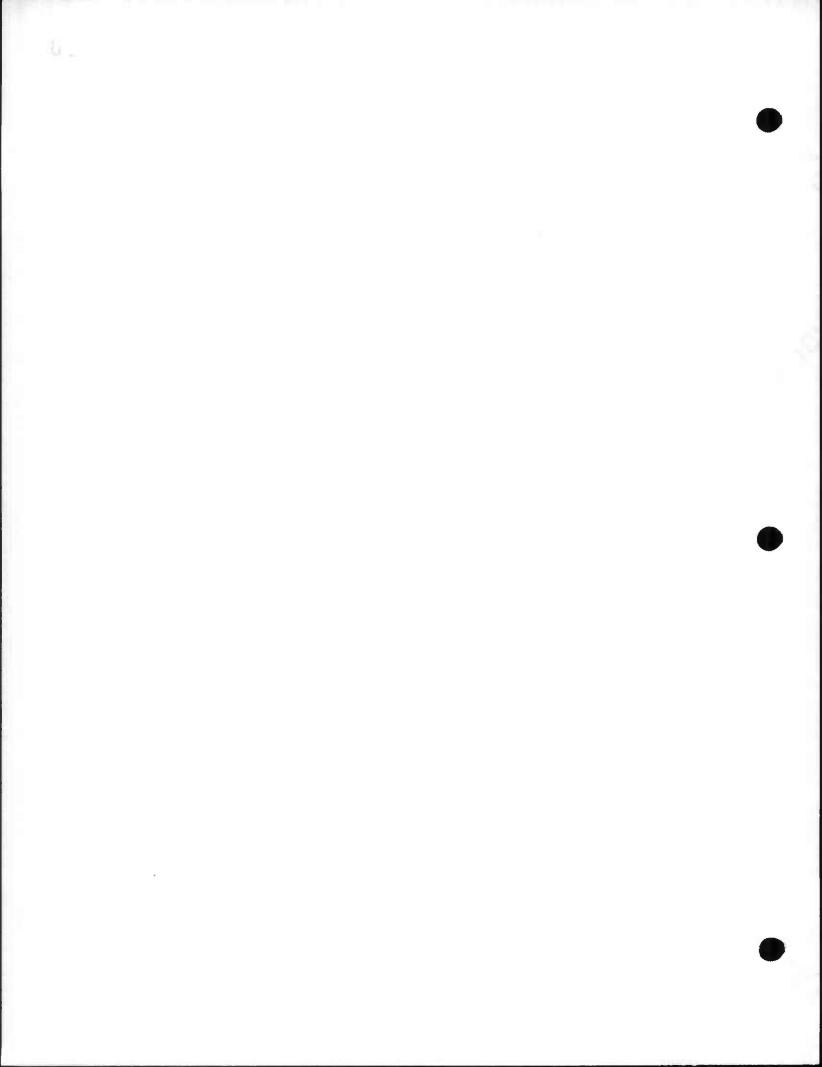
TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 75 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If hem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

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DIVISION	ATTENDISIO OLD
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	1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPART CERTIFIC	MENT OF H	EALTH AND I	MENTAL HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH	
	Gerald Robert	Waybright				Oct.29 19		2120 M	
	236 42 0045	5. SEX 8. AGE (In yrs. last birthday) 1 VRS. 1 VRS. 8. AGE (In yrs. last birthday) 1 FUNDER 1 YEAR IF UNDER 24 HMS. MONTHS DAYS HOURS MIN.				7. DATE OF BIRTH (Month, Day, Year) July 10		BIRTHPLACE (State or Foreign Country) W.Va	
Œ	90. FACILITY NAME (If not institution, give str Garrett Co. Mem.			ob. city, town o Oaklar	R LOCATION OF DE	ATH	9c. COUNTY		
570	RESIDENCE OF DECEDENT	HOSPICAL		Oaktai	a		Garre	tt	
DIRECTOR	W.Va Minera	al	1	Garden			10d. INSIDE CITY LIMITS? 1 YES 2 NO		
FUNERAL	Rt 4 Box 565			101	26726		10g. CITIZEN OF USA		
B	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 ☑ YES IF YES, GIVE WAR OR DA	2 NO	If yes, sp		IIC ORIGIN? (Specity Yea n, Puerto Ricen, atc.)	s or No — 14. RACE — American Indian, Black, White, etc. Specify White		
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12)	ATION completed) College (1-4 or 5+)	16a. OECEDENT'S U (Give kind of wo life. Do NOT use Coal Min	rk done during mo retired.)	ON st of working	16b. KINO OF BUS	SINESS/INDUST	RY	
BE COM	17. FATHER'S NAME (First, Middle, Lest) Bert Waybright					ME (First, Middle, Meiden Lambert	Surneme)		
TO B	19a. INFORMANT'S NAME (Type/Print) Darlene Waybright	t	196, MAILING A Rt4 Bo	OORESS (Street o	nd Number or Rural F Keyser, W	Number, City or Town Va 26726	n, State, Zip Cod	(6)	
	20a. METHOD OF DISPOSITION 1 Burlet 2 Cremation 3 Remove 4 Donetion 5 Other (Specify)	val from State 20b.	PLACE AND DATE OF elery, cremetory or other albaugh C	DISPOSITION (Ne		DATE 20c. LO	Cardon — City		
	21. SIGNATURE OF FUNERAL SERVICE LICE	Budock	g	David	A. Buro	lock Funera	al Home		
z	23. PART (. Enter the disesses, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest, shock, or heart fellure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Cerebrovascular Accident DUE TO (OR AS A CONSEQUENCE OF): Carotid Arterial Partial Occlusions								
CERTIFICATION	Sequentially list conditions, if any, lasding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in deeth) LAST	CONSEQUENCE OF):	DNSEQUENCE OF):				2 yr.		
ALC			ut not resulting in the underlying ceuse given in F					24b. WERE AUTOPSY FINDINGS	
PHYSICIAN: MEDIC	Insulin -depe Atrial Flutte		es Melli	Mellitus			MED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
≥ Z	DID TOBACCO USE CONTR	IBUTE TO CAUSE O	F DEATH YES	NO [UNCERTAIN			1 TES 2 NO	
CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 37	HOSPITAL:	26. PLACE OF OEATH						
IXSI	1 ☐ YES 2 1 NO	1 Tinpatient 2 ER/Outpo	atient 3 DOA 4		5 - Residence	6 Other (Specify)			
ВУ РН	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	28e, DATE OF INJURY (Month, Day, Year)	28b. TIME INJUS	M 1 U	RK? ES 2 NO	28d. DESCRIBE HOW II	NJURY OCCURE	D	
	3 Suicide 8 Could not be determined	26a. PLACE OF INJURY building, atc. (Speci	26a. PLACE OF INJURY — At home, term, streat, fectory, office building, atc. (Specify)			28t. LOCATION (Street e City or Town, State)	nd Number or Re	ural Route Number,	
COMPLET		IAN: To the best of my knowlers on the basis of examination						use(e) end menner ee stated.	
TO BE	296. SIGNATURE AND TITLE OF CERPIFIER		MD		D27205	BER	≥ 10/2	NED (Month, Day, Year)	
-	30. NAME AND ADDRESS OF PERSON WHO								
	Karl E. Schwalm 31. DATE FILEO (Month, Day, Year)	311 N. 4th		Land, M	21550				
1	OCT 3 1 1995	Sz. negistran s signi	or Revolate		-				



1, 2, 3 should	
Pages	
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed writing at nours after death. Tage b may be retained by the house at the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit.	PORTANT: if them 28 is marked or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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E FUNER	CTANT
는 다른 의로 기계를 가는 다른 기계를 가는	IMPOR
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	1 - STATE OF MA	RYLAND / DEPAR CERTIF	TMENT OF H		ENTAL HYGIENI REG. NO.	E		
	1. DECEDENT'S NAME (First, Middle, Last) Richard Michael Wynkoo	p			ndate of Death	, 1995°	3. TIME OF DEATH 1:30 a M	
	4. SOCIAL SECURITY NUMBER S. SEX	Month Day Wart						
TOR	9a. FACILITY NAME (If not institution, give street and number) Hyattsville Manor Nursing RESIDENCE OF DECEDENT	Н	Prince	George				
DIRECTOR	10e. STATE 10b. COUNTY Maryland Montgomery	y, town or Locat urtonsvi				10d. INSIDE CITY LIMITS? 1 YES 2X NO		
RAL	100. STREET AND NUMBER 3730 Angelton Court	101	ZIP CODE		10g. CITIZEN OF WHAT COUNTRY?			
BY FUNERAL	11. MARITAL STATUS 12. WAS DECEDENT	YES 2 NO R OR DATES	10 If yes, specify Cuban, Mexican, Puerto Rican, atc.) Bis				CE — American Indian, ock, White, atc.	
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ years	18a. DECEDENT'S			166. KIND OF BUS	opal Chi		
OM	17. FATHER'S NAME (First, Middle, Last)	12100		18. MOTHER'S NAME	(First, Middle, Maiden		az 011	
BEC	Alfred Russell Wynkoop				lizabeth	-		
2	19a, INFORMANT'S NAME (Type/Print) Donald Wayne Wynkoop			Court B			yland 20866	
	20a. METHOO OF DISPOSITION 1 □ Burlal 2 ★ Cremetion 3 □ Removal from State 4 □ Donation 6 □ Other (Specify)	20b. PLACE AND DATE Cappetery, crematory or of Metro Cre	OF DISPOSITION (Na	me of	OATE 20c. LO	cation — City or tonsvil	Town, State	
	21. SIGNATURE OF FUNERAL SERVICE LICENSES	THEELO CLE	22. NAME AP	o Aodress of Facilidadon Fune:	ral Home	P.A.	ryland 20707	
	Tooditing in douting	ED IMMUNE I	DEFICIEN	de of dying, such s	es cardisc or respi	ratory srrest,	Approximate interval Between Onset and Death UNKNOWN	
CERTIFICATION	Sequentially list conditione, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
MEDICAL CI	PART II. Other eignificent conditions contributing to deeth but not resulting in the underlying cause given in Part i. Mycobacterium avium—intracellulare, CMV meningitis, pancytopenia, wasting syndrome, dementia 244. WAS AN AUTOPSY PINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 VES 2 NO							
	DID TOBACCO USE CONTRIBUTE TO CAL			UNCERTAIN	1		1 YES 2 NO	
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 Inpettent 2	28. PLACE OF DEA	TH (Check only one)	e 5 🗆 Residence 6	Other (Specific)			
	27. MANNER OF DEATH 1 Natural 5 Pending 28e. OATE OF II (Month, Day	JURY 28b. TIN	AE OF 28c. INJ		ed. DESCRIBE HOW II	NJURY OCCURED		
TED BY	3 Suicide 28a. PLACE OF	INJURY — A1 home, farm, tc. (Specify)	stree1, 1ectory, offic	2	81. LOCATION (Street a City or Town, State)	and Number or Run	al Route Number,	
COMPLETED	29a. CENTIFINA (Check and 1 CERTIFYING PHYSICIAN: To the best of n 2 MEDICAL EXAMINER: On the best of axe						e(a) and menner as stated.	
BE	29b. SIGNATURE AND TITLE OF CENTIFIER	mas P	N	29c. LICENSE NUMBE DO1495			er 24, 1995	
٥	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE LEWIS HILLIARD DENNIS, M.I			belt Rd.	College I	Park, MI	20740	
31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE								

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPIAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within at hours after death. Page 6 may be retained by the hospital or attending physician.	10 THE RUMENT, UNESTURE Arm this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2	be filed written 72 hours after event with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT. If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
HE HOSPITAL OR ATTENDIN	NE FLIMERAL DIRECTOR: AN	ed within 72 hours after dea	DRTANT: If Item 28 is n
8	R	25	¥

3 should

	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPART	MENT OF HE	EALTH AND I	MENTAL HYGIEN		
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH
	William Ben	jamin Ware				10-23-9		07.48 AM
	4. SOCIAL SECURITY NUMBER		In yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	a BIE	ATHPLACE (State or Foreign untry)
	549-28-2563	1 XM 2 - F	76 YRS.	MONTHS DAYS	HOURS MIN.	(Month, Day, Year)	18	USA
~	9a. FACILITY NAME (If not institution, give st	reet and number)		9b. CITY, TOWN OR			9c. COUNTY OF	F DEATH
DIRECTOR	400 Webb Lane			Havre	de Grad	ce	На	rford
JEC	10a. STATE 10b. COUNTY	1	10c. CITY,	TOWN OR LOCATIO	ON			10d. INSIDE CITY
		rford		Havre :	De Gra	ce		LIMITS? 1 XYES 2 NO
3AL	10e. STREET AND NUMBER				ZIP CODE			F WHAT COUNTRY?
FUNERAL	400 Webb Lane				21078		US	
	1 Never Married 2 Married	12. WAS DECEDENT EVER IN FORCES? 1 XYES IF YES, GIVE WAR OR DA	2 NO	If yes, spec	ify Cuben, Mexica	IIC ORIGIN? (Specify Yes n, Puerto Rican, etc.)	BI	ACE — American Indian, ack, White, atc.
BY	3 Widowed 4 Divorced	WWII and		1 U YES 2	NO Specify	r:	Sp	White
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade		16a. DECEDENT'S U	SUAL OCCUPATION	of working	166. KIND OF BUS	SINESS/INDUSTRY	
Ä	Elementary/Secondary (0-12)	College (1-4 or 5+)	Ille. Do NOT use	retired.)		Towns and		
MF	17. FATHER'S NAME (First, Middle, Last)	5	Signa	I Corps				overnment
Ö	Richard Polastri	i				ME (First, Middle, Maiden	Surname)	
BE	19a. INFORMANT'S NAME (Type/Print)		19b, MAILING	DDRESS (Street and		Ware Route Number, City or Tow	n State 7in Code)	
2	Michael W. Ware					e de Grac		21078
	20a. METHOD OF DISPOSITION 1 Durist 2 Cremation 3 Remo	20b.	PI ACE AND DATE OF	DISPOSITION (Nom	a of	DATE 200 LO	CATION CIA. as	Town Odnie
	4 Donation 5 Other (Specify)	R	A. Ferr	is & Co.	, Inc.	10/26 V	Vest Ch	ester. PA
	21. SIGNATURE OF FUNERAL SERVICE THE	ENSEE		22. NAME ANO	ADDRESS OF FA	h Funeral		
	- Alley Cl	- yourk		Havr	e de Gr	ace, MD	21078-3	197
	23. PART I. Enter the diseases, or c	omplications that caused List only one cause on e	the death. Do no	t enter the mode	e of dying, sucl	h as cardisc or respi	ratory srrest,	Approximate
	IMMEDIATE CAUSE (Final	not only one order on ea	poil mile.					Interval Between Onset and Death
	disease or condition resulting in death)	Acute Cor	conary A	rtery	Diseas	е		
	_	ASCVD	CONSEQUENCE OF)					
0	Sequentially list conditions, if any, leading to immediate	b	CONSEQUENCE OF)					
3	cause. Enter UNDERLYING CAUSE (Disease or injury	c						
	that initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF)					
CERTIFICATION	rossining in docum, excel	J						
	PART II. Other significent conditions			the underlying	cause givan in			4b. WERE AUTOPSY FINDINGS
MEDICAL		Hypertens	sion			1 YES 2		AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
ME								1 YES 2 NO
ä	DID TOBACCO USE CONTR				UNCERTAIN	1 🗆		
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	8. PLACE OF OEATH	(Check only one) OTHER;				
14S	1 TYES 2 NO 27. MANNER OF DEATH	28a. DATE OF INJURY	28b, TIME			8 Other (Specify)		
	1 Netural 5 Pending	(Month, Day, Year)	INJU		(7	28d. OEŞCRIBE HOW II		
BY	2 Accident Investigation 3 Suicide 8 Could not be	NA 28a. PLACE OF INJURY	— At home, farm, str		X		A Number or Rura	al Route Number,
COMPLETED	4 Homicide determined	building, atc. (Speci	NA			281. LOCATION (Street a City or Town, State)	A	
PLE	29a. CERTIFIER	CIAN: To the best of my knowle	edge, death occurred	at the time, data ar	nd placa, and dua	to the cause(s) and man	ner as stated.	
≥ !!	(Check only 1 CERTIFYING PHYSIC							
0	(Check only	R: On the besis of exemination	and/or investigation.	in my opinion, des	ith occured at the	titre, outs and prace, an	d dos to the cape	e(a) and manner as stated.
	(Check only	R: On the beals of examination			29c. LICENSE NUM	BER	29d. DATE SIONI	ED (Month, Day, Year)
뀖	(Check only 2 DMEDICAL EXAMINES 29b. SIONATURE AND TITLE OF CERTIFIER	R: On the beels of examination	DME	2	29c. LICENSE NUM			ED (Month, Day, Year)
	(Check only 2 TMEDICAL EXAMINES 29b. SIONATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WHO	R: On the beels of examination	DME TH (ITEM 27) (Type, F	rint)	D 2	1809	≥ 10-2	ED (Month, Day, Year) 2.4 – 9.5
띪	(Check only one) 2 MEDICAL EXAMINES 296. SIONATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WHO Ganesh S. Prail	COMPLETED CAUSE OF DEAD ON N. D. 18	DME TH (ITEM 27) (Type, F	rint)	D 2	1809	≥ 10-2	ED (Month, Day, Year) 2.4 – 9.5
뀖	(Check only 2 TMEDICAL EXAMINES 29b. SIONATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WHO	C COMPLETED CAUSE OF DEA	DME TH (ITEM 27) (Type, F	rint)	D 2	1809	≥ 10-2	ED (Month, Day, Year) 2.4 – 9.5

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. or Hearth and Mental Hygher prior to brind, cernation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event: the marked assumptions.

	FOR 1 - STATE REGISTRAR	STATE OF MARYLAN	ID / DEPAR	RTMENT OF	HEALTH AF	ND MENT	TAL HYGIEN	E	
	1. DECEDENT'S NAME (First, Middle, Last)	TO WINT	ER	Jr.			TE OF DEATH DA	"L 2	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER 5	75 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 H	IRS. 7. DA'	TE OF BIRTH onth, Day, Year) 0-25-19	BIRTNPLACE (State or Foreign Country)		
	Sa. FACILITY NAME (If not institution, give street	et and number)		9b. CITY, TOWN	OR LOCATION				OF DEATN
된 B	Harford Memorial Hospital Havre de G					e Gra	ce	ŀ	larford
DIRECTOR	10e. STATE 10b. COUNTY	larford	10c, CIT	C. CITY, TOWN OR LOCATION Havre de Grace					10d. INSIDE CITY LIMITS? 1 X YES 2 NO
AL	10a. STREET AND NUMBER			1	of. ZIP CODE			10g. CITIZE	N OF WHAT COUNTRY?
l H	1001 Graceview	Drive			210	78			USA
BY FUNERAL	11. MARITAL STATUS 1			13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Ye if yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify:			GIN? (Specify Yee to Ricen, etc.)	14. RACE — American Indian, Black, White, etc. Specify: White	
COMPLETED	15. DECEDENT'S EDUCAT (Specify only highest grade co.		Give kind of life. Do NOT ut	USUAL OCCUPAT work done during n se retired.)	TON nost of working	1	16b. KIND OF BUS	INESS/INDUS	ТПУ
MP S		5+	Ch	iroprac					
	17. FATNER'S NAME (First, Middle, Last)	o Winter, Sr					II, Middle, Maiden		- 11
TO BE	19a. INFORMANT'S NAME (Type/Print)	o willter, Sr		A CORER (Charles			yn W. H		
	Mrs. M. Mabel Wir	nter						and the same of	ce, MD 21078
Must be	20e. METNOD OF DISPOSITION 1		ACE AND DATE	OF DISPOSITION (Name of	D	ATE 20c. LOC	CATION — CIty	y or Town, State
	21. SIGNATURE OF FUNERAL SERVICE LICEN		, , , , , ,	22. NAME	AND ADDRESS C	OF FACILITY			
	1 Dalani	X Invo	+	Hav	re de (Grace	uneral MD	21078	-3197
and members	23. PART I. Enter the disesses, or conshock, or heart failure. List IMMEDIATE CAUSE (Final disease or condition resulting in death)	st only one cause on each	ilina.	Abde			erdiac or reapli		Interval Between
CERTIFICATION	Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF):								
MEDICAL	PART II. Other algnificant conditions of	PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO 24b. WERE AUTOPSY FINDINGS ANALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?							
	DID TOBACCO USE CONTRIE	BUTE TO CAUSE OF	DEATH YE	S I NO	UNCER	TAIN 🗆			1 YES 2 NO
PHYSICIAN:		26. IOSPITAL: ☑ Inpetient 2 ☐ ER/Outpetie		OTHER: 4 Nursing Ho					
ВУ РНУ	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	26a. DATE OF INJURY (Month, Day, Year)	26b. TIM	E OF 28c, IN	JURY AT ORK? YES 2 NO	28d. 0	DESCRIBE NOW IN	JURY OCCUR	DED
	3 Suicide 6 Could not be determined	26e. PLACE OF INJURY — building, stc. (Specify)	At home, farm, a	streat, factory, offi	ce	2er. Le	OCATION (Street ellity or Town, State)	nd Number or	Rural Route Number,
COMPLET		N: To the best of my knowledg							Buse(a) and manner as stated.
O BE C	29b. SIGNATURE AND TITLE OF CERTIFIER	M . I			29c. LICENSE			29d. DATE S	IGNED (Month, Day, Year)
1 2	30, NAME AND ADDRESS OF BERSON WHO C	COMPLETED CALLED OF DELET			1	_			1 -

WNO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print)

31. DATE FILE Morn. 49. 8-1995

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4 7	Filled	n.	0
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withward hours after death. Page 6 may be retained by the hospital or	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for	be filed within 72 hours after death with the State Oept. of Health and Mental Hygiene prior to bunal, cremation, or removal,	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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32. PEGISTRAP'S SIGNATURE
JAVA DAVELEON RONGELL

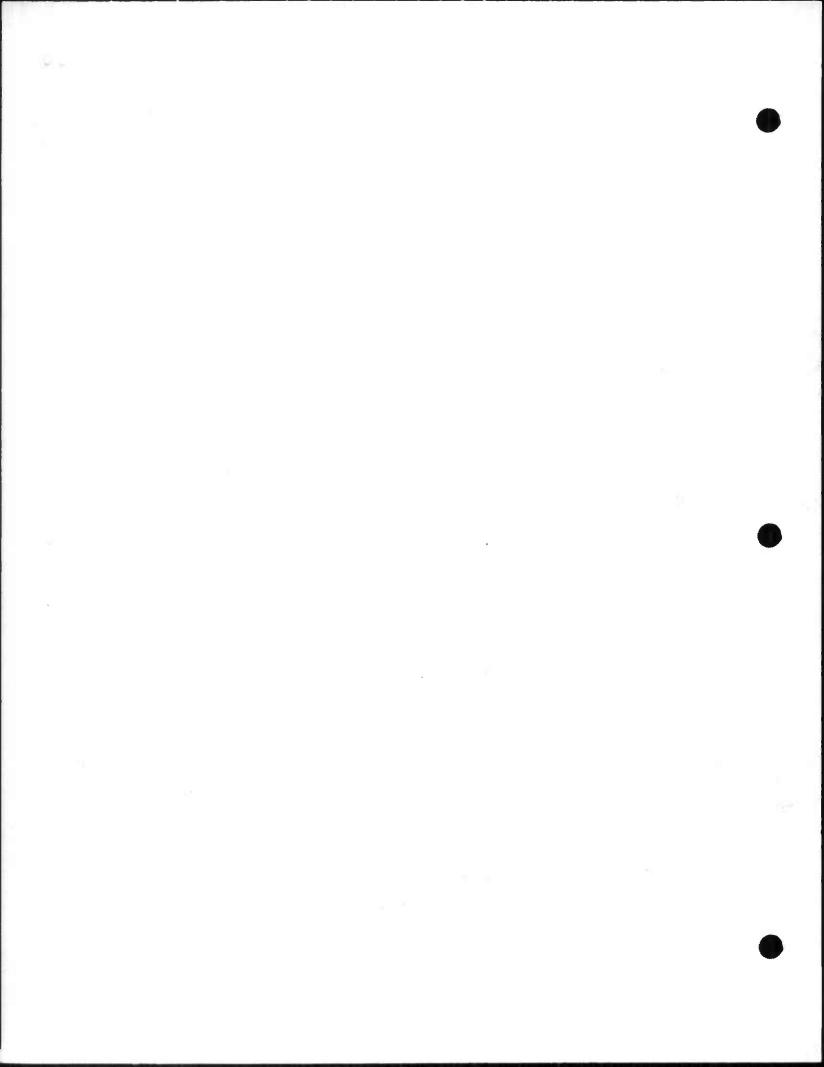
FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH YEAR 1 9 9 5 5 0 5 PAMELA JEAN WARREN OCTOBER 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER I YEAR IF UNDER 24 HRS. 579-74-5761 1 □ M 2 👿 F APRIL 23,1955 WASHINGTON, D.C. 40 9e. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR FORT WASHINGTON MEDICAL CENTER FORT WASHINGTON PRINCE GEORGE RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND PRINCE GEORGE FORT WASHINGTON 1 X YES 2 NO FUNERAL 10e. STREET AND NUMBER 101 ZIP CODE 10g CITIZEN OF WHAT COUNTRY? #9205 GENOA AVENUE 20744 UNITED STATES 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No—if yes, specify Cuban, Mexican, Puerto Rican, atc.)

1 YES XX NO Specify: 14. RACE — American Indian, Black, White, atc. 1 Never Merried 2XX Merried IF YES, GIVE WAR OR DATES BY 3 Widowed 4 Divorced BLACK 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION 16b. KINO OF BUSINESS/INDUSTRY (Specify only highest grade Ħ Flementery/Secondary (0-12) College (1-4 or 5 +) 4 YEARS COMPL GENERAL SERVICE ADM. GOVERNMENT 17. FATHER'S NAME (First, Middle, Last) 18 MOTHER'S NAME (First Mickella Maiden Surnama) WOODROW HARRIS NAOMI CLARK HARRIS BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number City or Town, State, Zio Code) 2 #9205 GENOA AVENUE, FORT WASHINGTON, MARYLAND 20744 KENNETH WARREN 20e. METHOO OF DISPOSITION 20h PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State 1X) Burlel 2 Cremation 3 Ramoval from State 4 Donation 5 Other (Specify) PLEASANT GROVE CHURCH CEM. 10/30/95 MARBURY, MARYLAND TYDIA C. THORNTON JOANSON MO0583 THORNTON FUNERAL HOME P.A. #3439 LIVINGSTON ROAD, INDIAN HEAD, MD. 20640 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fellure. List only one ceuse on each line. intervai Between Onsat and Death **IMMEDIATE CAUSE (Finel** disease or condition UREMIA 4 DAYS resulting in death) OUE TO (OR AS A CONSEQUENCE OF): SEVERE VOLUME DEPLETION (EFFECTIVE) CERTIFICATION 6 DAYS Sequentially ilat conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING MONTHS PANCREATIC CANCER CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): thet initiated events resulting in deeth) LAST PART ii. Other algnificent conditions contributing to deeth but not resulting in the underlying ceuse given in Part i. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL PERFORMED? AWAILABLE PRIOR TO HEPATIC FAILURE COMPLETION OF CAUSE 1 - YES 2 X NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\Boxed{1}\) NO \(\Boxed{1}\) UNCERTAIN \(\Boxed{1}\) PHYSICIAN: 26. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL HOSPITAL: OTHER:
4 | Nursing Home 5 | Residence 1 | Inpatiant 2 | ER/Outpatiant 3 | DOA 1 TYES 2 NO 27. MANNER OF DEATH 26e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 26c. INJURY AT WORK? 26d. DESCRIBE HOW INJURY OCCURED Netural 2 Accident 5 Pending 84 1 YES 2 NO BY Investigation 28e. PLACE OF INJURY -- At home, tarm, street, tectory, office 3 Suicide 281. LOCATION (Street and Number or Rural Route Number City or Town, State) 6 Could not be detarmined COMPLETED 4 Homicide 29e. CERTIFIER (Check only CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end piece, and due to the cause(e) end menner es stated. 2 MEDICAL EXAMINER: On the basic of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(e) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) H m DOCT. D21607 26 1995 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

washington rd. ft washington md 20744

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hosp	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: if item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
24 hours aft	y filled in by I	the medica
psecuted within	and completely burial, crema	natic event,
certificate be	ding physician hygiene prior to	r other traum
hat the death	and Mental F	ny Injury, or
aw requires the	s been signed opt. of Health	3 shows a
SICIAN: The I	certificate ha	, or item 2
ENDING PHYS	R: After this er death with	is marked
TAL OR ATTE	RAL DIRECTOR	If Item 28
TO THE HOSPI	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the f be filed within 72 hours after death with the State Dept, of Health and Mental Hyglene prior to burial, cremation, or removal.	IMPORTANT:

	1 - FOR STATE OF MARYLAN REGISTRAR	ND / DEPARTI	MENT OF H	EALTH AND	MENTAL	HYGIEN	E					
	1. DECEDENT'S NAME (First, Middle, Last) ADELE NICHOLS WILSON	S WILSON						2. DATE OF DEATH 3. TIME OF OCT 24, 1995 2:1				
	113-05-4859 1□M2▽F 85	yrs. last birthday) I	F UNDER 24 HRS. HOURS MIN.	July 15, 1910 8. BIRTHPLACE (STI				Ngn				
TOR	Pe. FACILITY NAME (II not institution, give street and number) Randolph Hills Nursing Home	Wheato	R LOCATION OF D		Montgomery							
DIRECTOR	100. STATE 10b. COUNTY Maryland Montgomery	10b. COUNTY 10c. CITY, TOV					10d. INSIDE CI LIMITS? 1 YES 2 X			10		
FUNERAL	10. STREET AND NUMBER 4011 Randolph Road		ZIP CODE			ed St	T COUNTRY?					
B	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced 12. WAS DECEDENT EVER IN U FORCES? 1 YES IF YES, GIVE WAR OR DATE	2 K NO	13. WAS DEC	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Ye if yea, specify Cuben, Mexican, Puerto Rican, etc.) 1 YES 2 X NO Specify:					American Indien	1,		
COMPLETED	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +)	SUAL OCCUPATION & done during most direct Publis Offic	t of working	U	.S. Go	usiness/industry overnment of Interior						
SON	17. FATHER'S NAME (First, Middle, Last)		02220	18. MOTHER'S NA				CIIOI				
BE	Henry Dodge Nicho		Adele			Lowber						
٥	Carolyn N. Cobb (Niece)	d, NW	ber or Rural Route Number, City or Town, State, Zip Code) NW Atlanta, GA 30327									
	206. METHOD OF DISPOSITION Buriel 2 N Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) DATE 20c. LOCATION - City or Chesapeake Crematory 10-26 Beltsville											
		00827	933 G	Funeral ist Ave.	, Sil	ver Sp	ring,		20910			
	25 DART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line.									la lween		
	disease or condition resulting in death) Aspiration pneumonia								Onset and Week			
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):											
PHYSICIAN: MEDICAL	PART II. Other significent conditions contributing to deeth but Congestive Heart Failure, hypo						PRMED? AMAILA		UBE			
AN	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES □ NO 💆 UNCERTAIN □											
SICI	EXAMINER? 1 YES 2 X NO HOSPITAL: 1 Inpetient 2 ER/Outpatie		THER:									
Ä	27. MANNER OF DEATH 28s. DATE OF INJURY	28b. TIME O	F 28c. INJU	IRY AT	6 Other (Specify) 28d. DESCRIBE HOW INJURY OCCURED							
M 1 YES 2 NO 2 Accident Investigation 3 Suicide 6 Could not be building, stc. (Specify) 289. PLACE OF INJURY — At home, ferm, street, factory, office building, stc. (Specify)							The second secon					
							and Number or Rural Route Number,					
COMPLETE	29e. CERTIFIER (Check only one) 1 X CERTIFYING PHYSICIAN: To the best of my knowledge one) 2 MEDICAL EXAMINER: On the basic of examination as								d manner as sta	led.		
BE	29b. SIGNATURE AND TITLE OF CERTIFIER	(3		29c. LICENSE NUI								
2	30. NAME AND ADDRESS OF PERSON WHO COMPLETED GAUSE OF DEATH Martin C. Shargel, M.D.			ut Ave,		inator	_		5, 1995			
	31. DATE FILED (Month, Dey, Your) OCT 2 7 1995 July Dawdion Road	IRE all	. arrag	uc Ave,	VEII2	riig con	, טויו	2005	95-2110			



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FINERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatte event, the medical examiner must be notified at once.

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH
REG NO.

	REGISTRAN				CENTIL			DEAL	* 1		HEG. NO.										
1	DECEDENT'S NAME (First, Middle, Lest) Malcolm Lamar Wood, Jr.									MONTH DAY YEAR			3. TIME OF DEATH 9:24 A M								
- 11					(In yrs. leat birthday) IF UNDER 1 1		1 YEAR	IF UNDER	-	7. DATE OF BIRTH				IPLACE (State or Foreign							
5	579-56-2898		1 🔀 M 2 🗆 F		53 YRS. MONTHS		DAYS	HOURS	MIN.	(Month, Day, Year)		1942	Wash	nington, DC							
	9e. FACILITY NAME (If not in	nstitution, give s	street and number)			96. CITY, TOWN OR LOCATION OF				ATH		9c. COU	NTY OF D	EATH							
	4320 Leland	1 Stree	et			Chevy Chase				Mc			ontgomery								
	RESIDENCE OF DECEDENT 10a, STATE 10b, COUNTY 10c, CITY																				
	Maryland Montgomery					Chevy Chase								10d. INSIDE CITY LIMITS? 1 X YES 2 NO							
	10e. STREET AND NUMBER						101	. ZIP CODE				10g. CIT	IZEN OF V	WHAT COUNTRY?							
	4320 Leland Street					20815			815		100	Uni	ited	States							
311	11. MARITAL STATUS 1. Never Married 2 Married 3 Widowed 4 Divorced 12. WAS DECEDENT EVER FORCES? 1 YES (IF YES, GIVE WAR OR I				2 XNO If yes, specify Cu			ecify Cubar	NT OF HISPANIC ORIGIN? (Specify Yea Cuban, Mexican, Puerto Rican, etc.) NO Specify:			Bleck, White, etc. Specify:		k, White, etc.							
		CEDENT'S EDU		16 a		S USUAL OCCUPATION				16b. KIND OF BUSINESS/INDUSTRY			DUSTRY								
	(Specify oni	ly highest grade	College (1-4 or 5		(Give kind o life. Do NOT	f work done use retired.)	during mo	at of working	g	Di	strict	of	Colu	ımbia							
	—	0-12)	4		Chief Lice		e E	xamin	er	Governme											
ı	17. FATHER'S NAME (First, M	Aiddle, Leat)								_	iddle, Maiden										
			r Wood, S	Sr							ise Gr										
			i wood, s	or.	105 44 6 11 15	O ADDRESS	D (Otro et e														
		19a. INFORMANT'S NAME (Type/Print) John Keates Wood					43 Allston Lane, Holl							0636							
	20a. METHOD OF DISPOSIT 1 & Burlai 2 Crematic 4 Donation 5 Other	on 3 🗆 Rem	noval from State	20b, PL/ cemeter)	oceand date	other piece)	Oct	ober	27,1	995TE	20c. LOC			DC							
	21. SIGNATURE OF FUNERAL SERVICE ACENSEE						Cemetery Washington, DC							rev Funera							
	Home/Bethesda-Chevy Chase, Inc., Wisconsin Ave., Bethesda, Marylan								7557 and 20814												
	IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Cirrhosis Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):																				
	PART ii. Other significant conditions contributing to death but not resulting in						nderiyin	g ceuse (PERFORMED? 1 VES 2 X NO OF D			b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 X NO									
: 10			DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN I																		
	DID TOBACCO U	JSE CONT	RIBUTE TO CA	AUSE OF D	DEATH Y	ES 🗌	NO L	1 UNC	CKIAII		25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one)										
	25. WAS CASE REFERRED 1	-							EKIAII	ושו											
		-	HOSPITAL:	26.	PLACE OF DE	OTHE	only one)				(Specify)										
	25. WAS CASE REFERRED TEXAMINER? 1 X YES 2 ND 27. MANNER OF DEATH	TO MEDICAL	HOSPITAL: 1 Inpatient 2 28s. DATE 0	26.	PLACE OF DE	OTHE	only one) R: rsing Hon 28c. IN	ne 5 XRe	naldence	6 Cother	(Specify)	NJURY O	CCURED								
	25. WAS CASE REFERRED TEXAMINER? 1 X YES 2 ND 27. MANNER OF DEATH 1 X Netural 5 2 Accident	-	HOSPITAL: 1 Inpetient 2 28a. DATE 0 (Month,	28. ER/Outpation F INJURY Day, Year)	PLACE OF DE	OTHE 4 Nui	only one) R: rsing Hor 28c. IN. W(DURY AT DRK?	naldence	6 Other	CRIBE HOW I										
	25. WAS CASE REFERRED TEXAMINER? 1 X YES 2 ND 27. MANNER OF DEATH 1 X Netural 5 2 Accident	TO MEDICAL	HOSPITAL: 1 Inputient 2 28a. DATE 0 (Month,	26. ER/Outpation FINJURY	PLACE OF DE	OTHE 4 Nui	only one) R: rsing Hor 28c. IN. W(DURY AT DRK?	naldence	6 Other	CRIBE HOW I			Route Number,							
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DIVISION OF VITAL RECORDS, P.O.	the same of the sa
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30-NAME AND ADDRESS OF PERSON ONALD

31. DATE FILED (Month, Day, Year)

1995

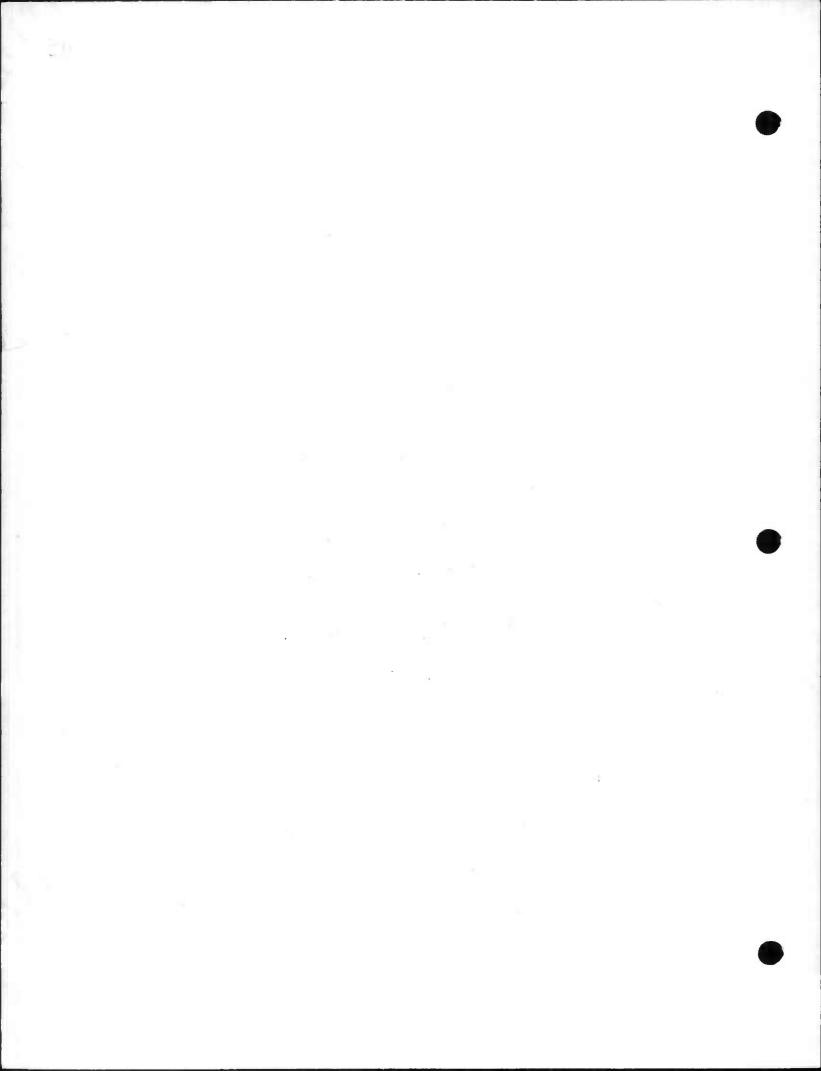
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	1. DECEDENT'S NAME (First, Middle, Last)									EATN		3. TIME OF DEATH	
	Evelyn B. Will							October 23, 1995			6:15P M		
	4. SOCIAL SECURITY NUMBER	5. SEX	8. AGE (In yrs. la	st birthday)	IF UNDE	R 1 YEAR	IF UNDER	24 HRS.	7. DATE OF BI	RTN	8. BIRTI	HPLACE (State or Foreign	
	119-26-4959	1 🗆 M 2 💢 F	91	YRS.	MONTHS	DAYS	HOURS	MIN.	April	18.190	Peni	nsylvania	
	9e. FACILITY NAME (If not institution, give si	reet end number)			9b, CITY	r. TOWN C	OR LOCATE	ON OF DE					
E .	Montgomery Ger	neral Hos	snital			lney				1	gomery		
18	RESIDENCE OF DECEDENT	icrar not	PICUI								Hone	50Mery	
DIRECTOR	10e. STATE 10b. COUNTY		10c. CIT	Y, TOWN	OR LOCAT	ION					10d. INSIDE CITY		
	MD Montg	- m d C under a							1 YES 2 NO				
¥	10e. STREET AND NUMBER					101	. ZIP CODE	E		10g. (TIZEN OF	WHAT COUNTRY?	
FUNERAL	17840 Quaker I		20860					USA					
15	11. MARITAL STATUS	12. WAS DECEDEN	T EVER IN U.S. A						IIC ORIGIN? (Sp	ecify Yes or No-	- 14. RAC	E — American indian, k, White, etc.	
BY F	1 Never Married 2 Merried 3 Widowed 4 Divorced	IF YES, GIVE V		2 (NO If yes, specify Cuban, Mexico					n, Puerto Rican, /:	etc.)	Spec		
ED B	***************************************		Towns 1				Λ					White	
	15. DECEDENT'S EDUCATION (Specify only highest grade completed) [Give kind of work done during most of working life. Do NOT use retired.)							g	16b. KIND OF BUSINESS/INDUSTRY				
1 2	Elementary/Secondary (0-12) College (1-4 or 5+) Teacher								Education				
COMPLET	17. FATHER'S NAME (First, Middle, Last)		1	eacine	=1								
	Aaron Buss				18. MOTNER'S NAME (First, Middle, Meiden Surname) Ella Meister								
BE	10a INFORMANT'S NAME (Trac(Driet)						EIIA MEISCEI reet end Number or Rural Route Number, City or Town, State, Zip Code)						
2	Peter M. Williams 9418 Thrush Ln, Pote												
	The HETHOLOGY CHARLESTON												
1 □ Buriel 2 Cremetion 3 □ Removal from State cemetery, cremetory or other place)													
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE	NSEE PROPERTY OCT 25 Brentwood, MD 22. NAME AND ADDRESS OF FACILITY Hines-Rinaldi Funeral Hom								MD		
	· alan 1	Danu	020										
								_				Spring, MD	
	23. PART I. Enter the disasses, or c shock, or haart fallure.	omplications the List only one cau	t caused the de	aath. Do i a.	not anter	tha mo	da of dyl	ng, sucl	n se cardiac o	r respiratory	errest,	Approximats Interval Between	
	IMMEDIATE CAUSE (Fins) disease or condition											Onset and Daath	
	resulting in death) s											2 WKS	
	disease or condition resulting in death) s. Due to (or as a consequence of:) CIRONIC RENDE FAILURE 2/R5.												
NO	Sequentially list conditions,												
CERTIFICATION	csuse. Enter UNDERLYING												
FIC													
E	CAUSE (Disease or Injury that Initiated events resulting in death) LAST C. AUSE (Disease or Injury that Initiated events resulting in death) LAST C. AUSE (Disease or Injury that Injury that Injury that Initiated events resulting in death) LAST C. AUSE (Disease or Injury that Inj												
CE													
AL	PART # A12									WAS AN AUTOPS PERFORMED?	Y 24b	WERE AUTOPSY FINDINGS	
MEDICAL	- OKINA	E/ /H	PECI.	102						YES 2 NO		COMPLETION OF CAUSE OF DEATH?	
ME												1 NES 2 NO	
\ \ S	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLA	CE OF DEA									
S	EXAMINER? 1 YES 2 NO HOSPITAL: OTHER: 4 Nursing Name 5 Residence 8 Other (Specify)												
PHYSICIAN:	27. MANNER OF DEATH 280. DATE OF INJURY 28b. TIME OF 28c. INJURY AT 28d. OESCRIBE NOW INJURY OCCURED												
B≼	7 Netural 5 Pending M 1 YES 2 NO												
8	3 Suicide 6 Could not be determined 28e. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) 28e. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) 28e. LOCATION (Street end Number or Rural Route Number, City or Town, State)								Route Number,				
COMPLET	29e. CERTIFIER												
₩	(Check only 1 CERTIFYING PRYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.												
8	2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occured at the time, date and place, end due to the cause(e) and manner se stated.												
#	29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)												

WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
LEWIS 17D 4000 RT/08

32. BEGISTRAR'S SIGNATURE

MD 208.3

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TO THE HOSPITAL OR ATTENDING PHYSICIAN; The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG. NO 1. DETEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATN 3. TIME OF DEATH NTHONY 0620 00 OCTUBOR AM 4. SOCIAL SECURITY NUMBER 5. SEX 7. DATE OF BIRTH (Month, Day, Year) 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. a. BIRTNPLACE (State or Foreign 1 X M 2 | F 124-26-3129 62 New York Sept. 24, 1933 9e. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Shady Grove Adventist Hospital Rockville Montgomery RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION tod. INSIDE CITY <u>Maryland</u> t TYES 2 5 NO Montgomery Gaithersburg FUNERAL 10e. STREET AND NUMBER 10t. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 18325 Lost Knife Circle Apt. 20879 United States 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 X NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No- RACE — American Indian, Black, White, etc. It yes, specify Cuben, Mexican, Puerto Ricen, etc.)

1 YES 2 NO Specify: 1 Never Married 2 X Merried YES, GIVE WAR OR DATES Specify. BY 3 Widowed 4 Divorced White COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade completed) ive kind of work done Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) Programer Computer 17. FATNER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Meiden Surneme) Jacob Wojtaszek Salomea Tomaszek B 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 20879 Thomas G. Wojtaszek 18325 Lost Knife Circle Apt. 102 Gaithersburg, 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of commetery, crematory or other place) UCTOBER 25, 1995 20c. LOCATION — City or Town, State Gate of Heaven Mausoleum Bilver Spring, Maryland 22. NAME AND ADDRESS OF FACULTY Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Avenue Bethesda, Maryland 20814-21. SIGNATURE OF FUNERAL SERVICE LICENSEE isconsin 501 M00202 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert fellure. List only one cause on each line. Approximate Interval Between Onset and Death IMMEDIATE CAUSE (Finel disease or condition ETASTATIC TROSTATE YRS resulting in desth) DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentielly liet conditions, DUE TO (OR AS A CONSEQUENCE OF) If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disesse or Injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in desth) LAST PART II. Other significant conditione contributing to deeth but not resulting in the underlying ceuse given in Part I. 24e. WAS AN AUTOPSY PERFORMED? MEDICAL AVAILABLE PRIOR TO COMPLETION DF CAUSE 1 TES 2 NO OF DEATH? 1 - YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES | NO X PHYSICIAN: UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) EXAMINER? HOSPITAL:
1 Inpetient 2 ER/Outpetient 3 DOA OTHER: 1 YES 2 NO ing Nome 5 🗔 Residence 28a. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATN 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending t YES 2 NO BY 2 Accident 3 Suicida 28e. PLACE OF INJURY — At home, term, street, tectory, office building, etc. (Specify) 281. LOCATION (Street end Number or Rural Route Number City or Town, State) 8 Could not be determined ETED. 4 Nomicide 29e. CERTIFIER (Check only CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) and manner as stated. COMPL 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(e) and menner as stated. 290 SIGNATURE AND TITLE OF CERTIFIE LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year, BE any (, Brown OCTOBER 19 07285 2 AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MEDICAL CENTER

32. REGISTRAR'S SIGNATURE

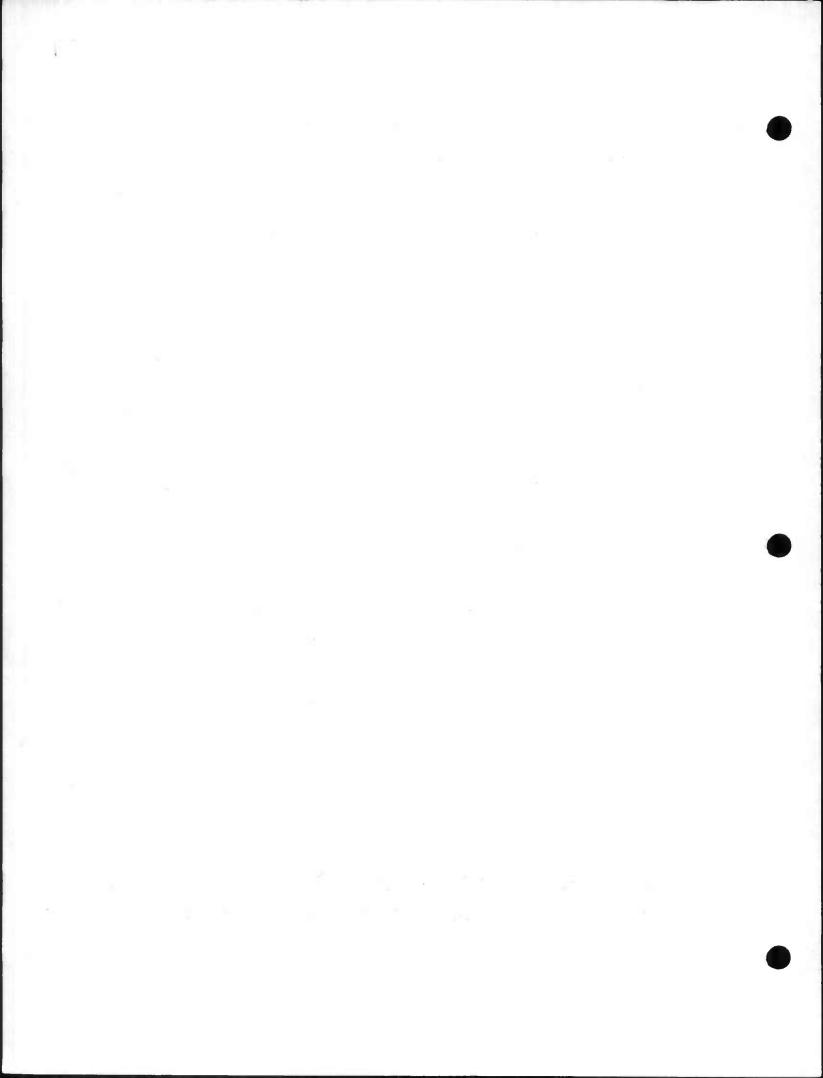


3t. DATE FILED (Month, Day, Year)

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	KENNETM	1 #	<i>U</i>	VILCOXO	NO	MONTH DA	9 9 YE	1331
	4. SOCIAL SECURITY NUMBER		AGE (In yrs. last birthday)			DATE OF BIRTH (Month, Day, Year)		BIRTHPLACE (State or Fo
	325-07-1940	1 X M 2 🗆 F	83 YRS.		A	ug. 21,1	912	Iowa
~	9a. FACILITY NAME (If not institution, g			9b. CITY, TOWN OR LO			9c. COUNTY	
СТОВ	Shady Grove Adve		tal	Rockvi	TTe		Monto	jomery
ш	10a. STATE 10b. CO		10c. CIT	Y, TOWN OR LOCATION				10d. INSIDE CITY
DIR.		Montgomery		Gaithe			,	1 - YES 2 X
RAL	10e. STREET AND NUMBER	7.7		10f. ZIP	879			OF WHAT COUNTRY?
FUNER	9537 Fern Hollov	12. WAS DECEDENT EV	/ER IN U.S. ARMED			ORIGIN? (Specify Yes		States RACE - American India
	1 Never Married 2 Married	FORCES? 1 I		If yes, specify	Cuben, Mexican, Pr	uarto Rican, etc.)		Black, White, etc. Specify:
D BY	3 Widowed 4 Divorced							White
ETED	15. DECEDENT'S (Specify only highest of	grade completed)	16a. DECEDENT'S (Give kind of life. Do NOT u	USUAL OCCUPATION work done during most of se retired.)	working	16b. KIND OF BU	SINESS/INDUST	RY
	Elementary/Secondary (0-12)	College (1-4 or 5 +) 4	Inve			Self E	mployed	3
COMPL	17. FATHER'S NAME (First, Middle, Last				MOTHER'S NAME	First, Middle, Meiden		-
ш	Clyde Welby W:	ilcoxon			Mea	rla Wedg	е	
TO B	19a. INFORMANT'S NAME (Type/Print)			ADDRESS (Street and N				-,
	Maurine M. Wilco	oxon		Fern Hollo	-			
	20a. METHOD OF DISPOSITION 1 Burlel 2 Acremetion 3 D		cemetery, crematory or c	OF DISPOSITION (Name of Other place)	er 20, 1	995 20c. LO	CATION — City	
	4 ☐ Donation 5 ☐ Other (Specify) . 21. Signature OF Funeral Service		Montgomer	y Cremator	DDRESS OF FACILITY	. Bet	nesda,	Maryland ophrey Fun
	A.	0	1	Home/Ro	ckville.	Inc., 3	00 W. N	Montgomery
	// HIADADA							
	- U MARCELE	· Juli	M0034	8 Rockvil	le, Mary	land 20	850-280	
	23. PART I. Enter the diseases, shock, or heart falls	or complications that caura. List only one cause	used the death. Do	8 Rockvil	le, Mary	land 20		Approxim
	23. PART I. Enter the diseases, ahock, or heart falls iMMEDIATE CAUSE (Final disease or condition	ura. List only one cause	on each line.	8 Rockvil	le, Mary	land 20		Approxim interval B
	iMMEDIATE CAUSE (Final	ura. List only one cause	on each line.	8 Rockvil	le, Mary	land 20		Approxim interval B
Z	iMMEDIATE CAUSE (Final disease or condition resulting in death)	a. ARDIC 6 DUE TO (OR	as a consequence of	8 Rockvil	le, Mary	land 20 a cerdiec or reep	Iratory arrest,	Approxim interval B
TION	immediate Cause (Final disease or condition resulting in death) Sequentially liet conditions, if any, isading to immediate	a. CARDIC & DUE TO (OR	used the death. Do on each line. -EW/C AS A CONSEQUENCE O	Rockvil not enter the mode of	le, Mary	land 20 a cardiac or reap	Iratory arrest,	Approxim interval B
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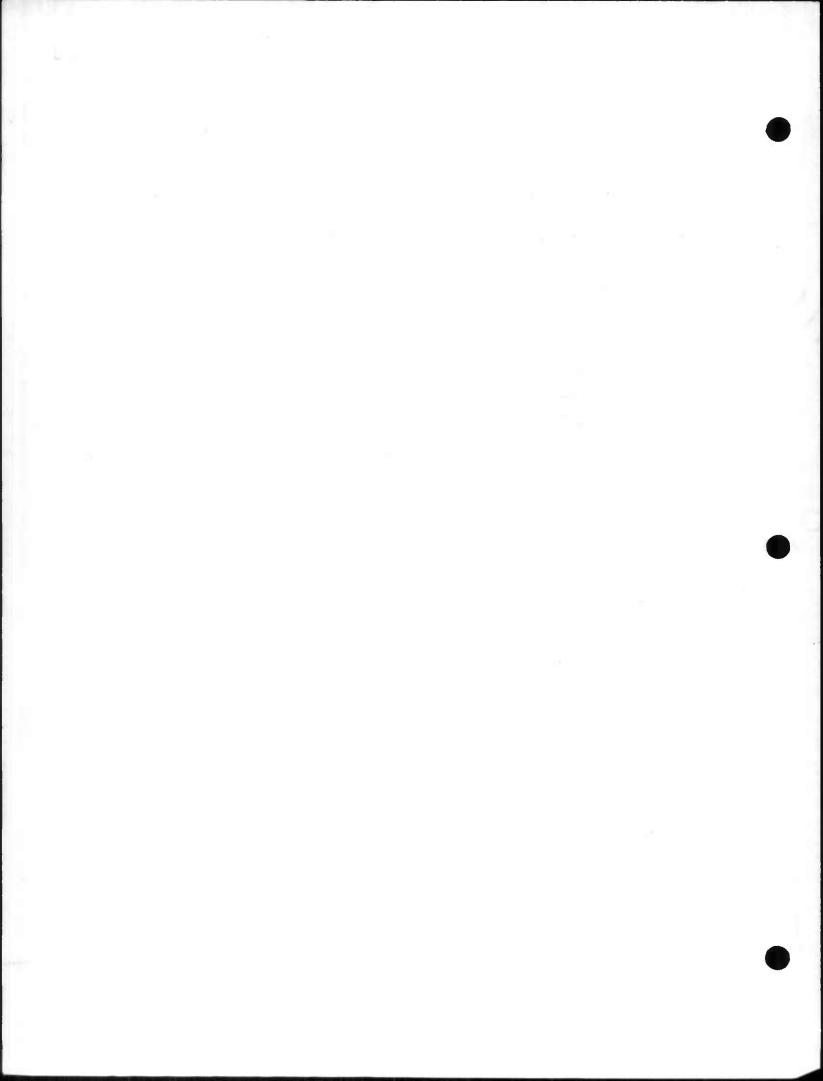
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buriat-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to buriat, cremation, or removal.

IMPORTANT: It tiem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be neitfied at once.

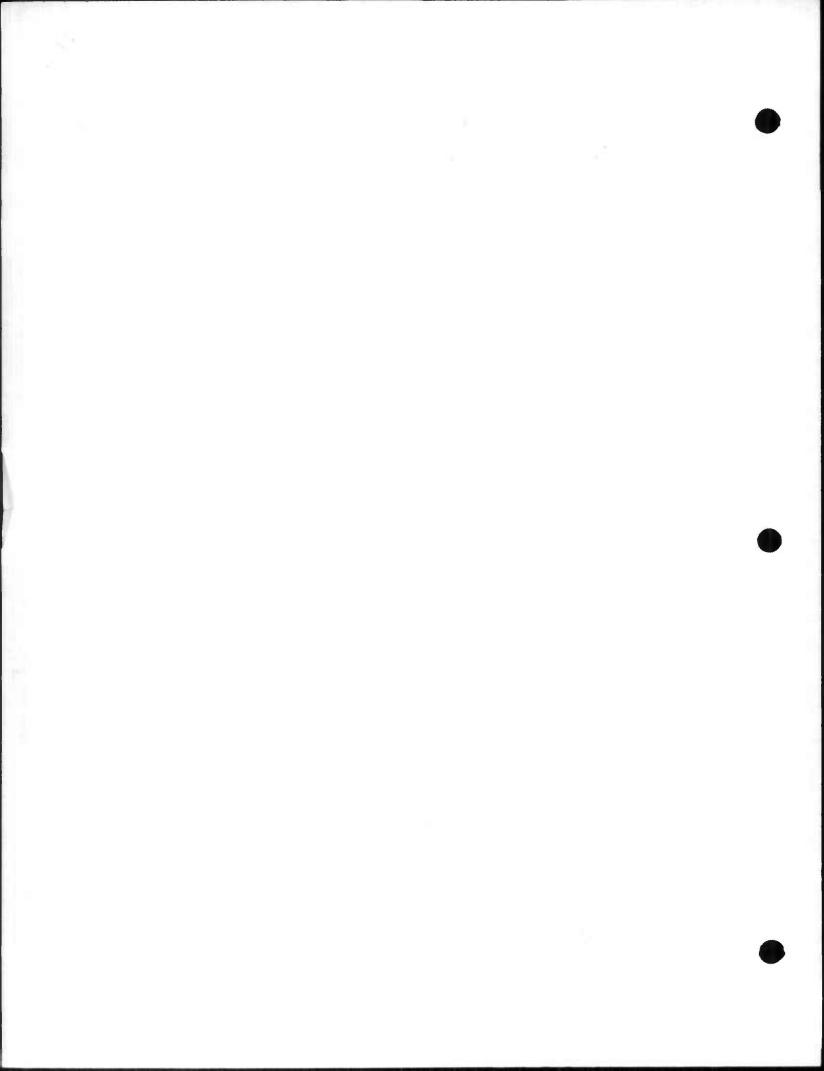
STATE OF N	MARYLAND /	DEPARTMENT	OF HEALTH	AND	MENTAL	HYGIENE
	CE	RTIFICATE	OF DEAT	H		REG NO

	FOR 1 - STATE REGISTRAR	STATE OF MARYL		ENT OF HEALTH AN	ID MENTA	L HYGIEN	E		
- 1	1. DECEDENT'S NAME (First, Middle, Last)					OF DEATH		3. TIME OF DEATH	
	Donald	Edward V	Werden		OCT		, 1995	2:10 P	M
	4. SOCIAL SECURITY NUMBER		In yrs. last birthday) IF U	INDER 1 YEAR IF UNDER 24 H	RS. 7. DATE	OF BIRTH	8. E	NRTHPLACE (State or Foreign	
	579-56-9589		O YRS. MON	THE DAYS HOURS M	Dec	. 21,19		shington, D.C	
DIRECTOR	2100 Viewpoint Co			rookeville	PEATH			gomery	
E I	10a. STATE 10b. COUNT	Υ	10c. CITY, TO	WN OR LOCATION				10d. INSIDE CITY	
		ntgomery	Brook	eville				t YES 2 NO	
3AL	toe. STREET AND NUMBER			101. ZIP CODE			10g. CITIZEN	OF WHAT COUNTRY?	
FUNERAL	2100 Viewpoint Co			2083			US	A	
5	11. MARITAL STATUS 1 Never Married 2 X Married	12. WAS DECEDENT EVER II FORCES? 1 YES	VU.S. ARMED 2 NO	13. WAS DECENDENT OF HI If yes, specify Cuben, M			or No— 14.	RACE American Indian, Black, White, atc.	
BY	3 Widowed 4 Divorced	IF YES, GIVE WAR OR D		1 TYES 2 TO NO S		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Specify	
	15, DECEDENT'S EDU	ICATION	18a. DECEDENT'S USU		Tio			White	_
COMPLETED	(Specify only highest grade	completed)	(Give kind of work i	done during most of working	16	b. KIND OF BUS	SINESS/INDUST	RY	
١٣	Elementary/Secondary (0-12)	College (1-4 or 5+)		,		C-16 T	2		
M	12 17. FATHER'S NAME (First, Middle, Last)		Printing	Distributor	-		Employe	α	_
		** 1				Middle, Maiden			
BE	Charles Whittelse	y Werden			6		Herbe		
2				RESS (Street and Number or I					
	Frances S. Werder			wpoint Court	-	7	le,Mary		_
	t Burial 2 ☐ Cremation 3 ☐ Ram	noval from State cen	PLACE AND DATE OF DI- netery, crematory or other p	(ace)	DA		CATION — City	The second second	
Ц	4 Donation 5 Other (Specify)	IGa	te of Heav	en Cemetery		/95Sil	ver Spr	ing, Maryland	
- 1	211	1/00	00	Francis J. (s Funer	al Hom	e. Inc.	
	1//ach -	1/iller		500 Universi					
LION	23. PART i. Enter the diseases, or shock, or heert fellure. IMMEDIATE CAUSE (Finei disease or condition resulting in death) Sequentially list conditions, if any, leeding to immediate	e. DUE TO (OR AS A	ech line.	Adenoca			. (Onnet and Deat	
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or injury that Initiated eventa reaulting in desth) LAST	cause. Entar UNDERLYING CAUSE (Disease or injury that Initiated eventa OUE TO (OR AS A CONSEQUENCE OF):							
EDICAL	PART II. Other significant condition	ne contributing to death b	out not resulting in th	e underlying ceuse give	n in Part I.	24a. WAS AN PERFOR	RMED?	24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 PNO	š
PHYSICIAN: M	DID TOBACCO USE CONT	RIBUTE TO CAUSE C	F DEATH YES	NO UNCER	TAIN 🗆				
¥.	25. WAS CASE REFERRED TO MEDICAL		28. PLACE OF DEATH	heck only one)		1			
SE	1 TYES 2 ONO	HOSPITAL: 1 Inpetient 2 ER/Out		HER: Nursing Home 5 KReside	nca 8 🗆 Oth	er (Specify)			
Ť	27. MANNER OF DEATH	28e. DATE OF INJURY	28b. TIME OF	28c. INJURY AT			NJURY OCCUR	ED	
(Month, Day, Year) INJURY WORK? M 1 YES 2 NO									
ED BY	28a. PLACE OF INJURY — At home, ferm, atreel, factory, office building, atc. (Specify) 28a. PLACE OF INJURY — At home, ferm, atreel, factory, office City or Town, State)								
91	IN. CERTIFIER	1							_
COMPLETED	(Check My CENTIFTING PHTS	BIOTAN: To the best of my know ER: On the bests of examination						use(s) end manner as stated.	
	29 GHAYURE AND TITLE OF CHITTE'S	m + e 11		29c. LICENS	E NUMBER		29d, DATE SI	GNED (Month, Day, Year)	
BE	1000 11 11 VXUI	MULI 1117		DAG	750	_	10,	T20 199	-
2	IO. NAME AND ADDRESS OF PERSON W	COMPLETED CAUSE OF OF	ATH (ITEM 27) (Type, Prin	1)	137		06	La Cyllic	1
	/	79.4"							
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGN	IATURE						-
	OCT 2.9 100F	di. As is	0						



DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020	
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be seecuted within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	
TO THE FUNERAL DIRECTOR: After this cartificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	
MPORTANT: if Item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.	

	1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPAR CERTIF	TMENT OF HEALTH A	ND MENTA	L HYGIENE REG. NO.	
	1. DECEMENT'S NAME (First, Middle, Last)	Yuter	,		2. DATE	OF DEATH	YEAR 1 TIME OF GEATING
	217-24-5765	1) M 2 🗆 F	19 yrs. lest birthday) YRS.		3	72032	a. SHITHPLACE (State or Funda Country) MARYLAND
TOR	99. FACILITY NAME (If not institution, give ANNE ARUNDEL ME RESIDENCE OF DECEDENT			9b. CITY, TOWN OR LOCATION ANNAPOLIS	OF DEATH /	1	NE ARUNDEL
DIRECTOR	19a, STATE 19b, COUNT	E ARUNDEL		Y, TOWN OR LOCATION			10d. INSIDE CITY LIMITS? 1 K YES 2 NO
FUNERAL	100. STREET AND NUMBER 1803 LINCOLN DR	IVE		101. ZIP CODE 21	.401	10g. Cl	USA
B	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER II FORCES? 1 TYPES IF YES, GIVE WAR OR D	2 NO	13. WAS DECENDENT OF If yee, specify Cuben, 1 YES 2 NO	Maxican, Puerto		14. RACE — American Indian, Black, White, etc. Specify: BLACK
LETED	15. DECEDENT'S EDG (Specify only highest grad Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind of v life, Do NOT us		161	b. KIND OF BUSINESS/IN	NDUSTRY
COMPL	12th 17. FATHER'S NAME (First, Middle, Last) LOUIS PORTER	0	VENDOR		-73	PEPSI COLI	
TO BE	19a. INFORMANT'S NAME (Type/Print) SUSIE A. PORTER			ADDRESS (Street and Number or INCOLN DRIVE		nber, City or Town, State, Z	
Must be	20a. METHOD OF DISPOSITION 1 Surial 2 Cremation 3 Ren 4 Donation 5 Other (Specify)	noval from State CON	o. PLACE AND DATE	OF DISPOSITION (Name of	DAT	TE 20c. LOCATION -	- City or Town, Stata
CYCLE	21. SIGNATURE OF FUNERAL SERVICE LICENSEE HAVE AND ADDRESS OF FACILITY REESE & SONS MORTUARY, P.A. 821 WEST ST ANNAPOLIS MD 21/401						
CERTIFICATION	23. PART I. Enter the diseeses, or shock, or heert fellure. IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if sny, lesding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	a. Penal DUE TO (OR AS A DUE TO (OR AS A	A CONSEQUENCE OF	jelma			Approximates Interval Betw Opaet and Di
MEDICAL CE	PART II. Other significent condition	ns contributing to deeth b	out not resulting	n the underlying ceuse giv	en in Part I.	244. WAS AN AUTOPSY PERFORMED? 1 YES 2 MANO	AVAILABLE PRIOR TO COMPLETION OF CAUS OF DEATH?
AN:	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER?		28. PLACE OF DEAT		RTAIN 🗆		1 TYES 2 NO
YSICI	1 TYES 2 NO	HOSPITAL: 11/2 Inpetient 2 ER/Outp		OTHER: 4 Nursing Home 5 Resk	Sence 6 - Othe	er (Specify)	
BY	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	28e. DATE OF INJURY (Month, Day, Year)		M 1 YES 2	10	SCRIBE HOW INJURY OF	
PLETED	3 Suicide 8 Could not be determined		city)		City	CATION (Street and Number or Yown, State)	
= =	(Check only one) 2 MEDICAL EXAMINI	ER: On the besis of examination		d at the time, data and place, a			ated. the cause(s) and matrier as stated
TO BE CO	296. SIGNATURE AND TITLE OF CENTURE	Deut.	M	D08	194	29d. DA	TE SIGNED (Marinth, Day, Year)
	30. NAME AND ADDRESS OF PERSON WE JOHN J. C. P. P. S. S. S. S. S. S. S. S. S. S. S. S. S.	1. 1	07 RIA	gley Ave.	ANN	ra Md 2	1401
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	within 15 hours after death. Page 6 may be retained by the hospital or attending physicia
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STATE OF MARYLAN		ALTH AND MENTAL HYGIENE
	CERTIFICATE OF	DEATH REG. NO.

			1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPAR CERTIF	ITMENT OF I	HEALTH AND I	MENTAL HYGII			
			1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		YEAR 3.	TIME OF DEATH
			PEARL M. ADCOCK a						1995		10:00 PM
			4. SOCIAL SECURITY NUMBER	5. SEX 8. AGE	(In yrs. lest birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year,)	Country)	ACE (State or Foreign
	3 should		216-16-6851 9a. FACILITY NAME (If not institution, give	Δ	79 THS.	9b. CITY, TOWN	OR LOCATION OF DE	MARCH 12.	1916 T		
	1, 2, 3 sh	DIRECTOR	613 A ST.			PASADEN			ANNE		
		REC	10a. STATE 10b. COUNT	Υ	10c. CIT	Y, TOWN OR LOCA	TION			10	d. INSIDE CITY
	burial-transit permit. Pages			ARUNDEL	GLE	N BURNIE				t	☐ YES 2X☐ NO
	it per	FUNERAL	100. STREET AND NUMBER 6644 WHITMORE CT.	ADT 121 D			1. ZIP CODE		10g. CITIZE		T COUNTRY?
cian.	l-trans	JNE	11. MARITAL STATUS		N U.S. ARMED		1061	IIC ORIGIN? (Specify	Mag ag No. I de	USA	American Indian
5-0020	buria		1 Never Merried 2 Merried	12. WAS DECEDENT EVER II FORCES? 1 YES IF YES, GIVE WAR OR D	2 NO ATES	If yes, sp	pecify Cuban, Mexical 3 2 X NO Specify	n, Puerto Rican, etc.)	108 OF NO.	Black, W	American Indian, fhite, atc.
215-0020 attending physician.	as the	р Вү	¾☑ Widowed 4 □ Divorced				A			WHIT	E
	5	ETED	15. DECEDENT'S EDU (Specify only highest grade	e completed)	16a. DECEDENT'S (Give kind of a life. Do NOT us	VSUAL OCCUPATE work done during m	ON ost of working	16b. KIND OF	BUSINESS/INDUS	TRY	
D 2	ed for	PLE	Elementary/Secondary (0-12)	College (1-4 or 5 +)	HOMEMAI			OMN	HOME		
RYLAND 21 ed by the hospital or	detached once.	COMPL	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Middle, Maid			
	2 %	BE (JOHN C. BRANHAM				ELLA LU	CY CAMPBE	LL		
MARY!	5 should notified	0	19a. INFORMANT'S NAME (Type/Print)					Route Number, City or	Town, State, Zip Co	ode)	
400	age pe		PRESTON A. ADCOCK		D. PLACE AND DATE		ADENA, MD				
ALTIMORE, death. Page 6 may by			1 A Buriel 2 Cremetion 3 Rem 4 Donation 8 Other (Specify)		EN HAVE				EN BURN		
N S	iner		21. SIGNATURE OF FUNERAL SERVICE LI					NK FUNERA		TEST	
AL	the funeral director, val.		Still 2.	Xin !				SW. GLEN		MD	21061
S affer CD	d in by the or removal medical		23. PART i. Enter the diseases, or	complications that cause List only one cause on e	the death. Do r						Approximate
4 hours			IMMEDIATE CAUSE (Finei	Co.	ech line.						Interval Between Onset and Death
0	completely fille ial, cremation, event, the		reaulting in death)	e	١٠٠٠	3	ranc	rees		article (in the later)	
68760 executed wit	2 - E	_		DUE TO (OR AS A	CONSEQUENCE OF	1					
OX 6	sician and con rior to burial, traumatic er	<u> </u>	Sequentieily list conditions, if any, leading to immediate	DUE TO (OR AS A	CONSEQUENCE OF	F):					
BO cate b	80	CERTIFICATION	CAUSE (Disease or injury	C							
S, P.O. Bodeath certificate	attending phy nal Hygiene p y, or other	Ē	that initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF	F):					
	y the atter d Mental Injury, o	- 41	PART II Oshara la Mara	d							
2 4	25-	SAL	PART II. Other significent condition	ns contributing to deeth b	ut not resulting i	in the underlyin	g ceuse given in i		AN AUTOPSY ORMED?	AM	RE AUTOPSY FINDINGS AILABLE PRIOR TO
RECOR requires that	been signed b pt. of Health ar 3 shows any	MEDIC						1 _ YES	2 DNO	OF	MPLETION DF CAUSE DEATH?
CC 6	,E2 and .		DID TOBACCO USE CONT	RIBUTE TO CAUSE O	F DEATH YE	S D NO D	UNCERTAIN	-		1(YES 2 LINO
VITAL AN: The lav	State Dept.	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEAT						
77	certificate the State	HYSI	1 TES 2 THO	1 Inpatient 2 ER/Outp			no 5 Desitionce	8 Other (Specify)			
OF PHYSIC	with with	H	27. MANNER OF DEATH 1 Natural 5 Pending	(Month, Day, Year)	28b. TiM	URY WO	URY AT ORK? YES 2 NO	28d. DESCRIBE HON	W INJURY OCCUP	RED	
DIVISION OR ATTENDING	W O M	9	2 Accident Investigation 3 Suicide 8 Could not be	28e. PLACE OF INJURY	- At home, farm, a			281. LOCATION (Street	et and Number or	Rural Route	Number
VISION	28 afe	TED	4 Homicide determined	building, atc. (Spec	offy)			City or Town, Sta	te)		
DIN THE		PLE	29a. CERTIFIER (Check only	ICIAN: To the best of my know	ledge, death occurre	ed at the time, date	and place, and dua	to the cause(s) and n	nenner as atated.		
I THE HOSPITAL	TO THE FUNERAL be filed within 72 I IMPORTANT: If I	COMPLET		ER: On the beals of examination						ause(a) an	d manner as stated.
물	THE RI	BE	296. SIGNATURE AND TITLE OF CERTIFIE	R	7		29c. LICENSE NUM	BER	29d. DATE S	IGNED (Mo	onth, Day, Year)
2	E & W	2	30. NAME AND ADDRESS OF PERSON WIT	O COMPLETED CATTLE DE DE	ATT OF THE ATT OF	9	2/83	for	 	1	281
			01 7	4			T.T. #200	C.I	D	_	
	-		31. DATE FILED (Month, Day, Year)	M.D., 16	ATURE (rain F	LWY, #306	, Glen	Burnie	. M	d. 21061
	7		NOV 0 91995 A	le duderke	68						
											DHMH-18 Rev 1/89

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	PHYSICIAN:
	E HOSPITAL DR ATTENDING PHYSICIAI
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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with. In hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Memal Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MARYL		MENT OF HEALTH AND	MENTAL HYGIEN				
3	1. DECEDENT'S NAME (First, Middle, Last) DORIS WHI	5, 1995	3. TIME OF DEATH						
52			ORN In yrs. last birthday)	IF UNDER 1 YEAR IF UNDER 24 HRS	7 DATE OF BIRTH	0, BI	6:20 A M		
	219-10-1073	1 □ M 2 🔀 F 70	O YRS.	ONTHE DAYS HOURS MIN.	May 12, 1	Co	untry) iryland		
	9e. FACILITY NAME (If not institution, give street	it and number)		96. CITY, TOWN OR LOCATION OF		9c. COUNTY O			
DIRECTOR	6502 Alta Ave.			Baltimore	9	N/A			
EC	10a. STATE 10b. COUNTY		10c. CITY,	TOWN OR LOCATION			10d. INSIDE CITY		
	Maryland N/	'A	1	Baltimore			1 X YES 2 NO		
3AL	10e. STREET AND NUMBER			101, ZIP CODE		10g. CITIZEN C	F WHAT COUNTRY?		
FUNERAL	6502 Alta Ave.	T		2120		USA			
	1 Never Married 2 Merried	2. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2 V NO	13. WAS DECENDENT OF HISP If yes, specify Cuben, Mexi	can, Puerto Rican, etc.)	В	ACE — American Indian, lack, White, etc.		
ВУ	3 Widowed 4 Divorced	IF TES, GIVE WAR ON DA	MES	1 TYES 2 NO Spe	olfy:	Sı	White		
COMPLETED	15. DECEDENT'S EDUCAT (Specify only highest grade con	TION mpleted)	16a. DECEDENT'S U	rk done during most of working	18b. KIND OF BUS	SINESS/INDUSTR			
J.		College (1-4 or 5 +)	Ina. Do NOI usa	retired.)					
OMI	Unknown 17. FATHER'S NAME (First, Middle, Last)		Trust De	epartment Manac	NAME (First, Middle, Melden	ank			
BE C	William R. Whitef	ord			le V. Sewar	,			
TO B	19a. INFORMANT'S NAME (Type/Print)		19b. MAILINO A	DDRESS (Street and Number or Run					
۴	William J. Alcorn		6502 7	Alta Ave., Balt	imore, MD	21206			
	20e. METHOD OF DISPOSITION 1 N Buriel 2 Cremation 3 Remova	of from State 20b.	PLACE AND DATE OF	DISPOSITION (Name of profess)	DATE 20c. LO	CATION — City or			
	4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICEN	Du	laney va.	Ley Mem. Gdns.		imonium	MD		
	+ AK George (ellis		ALTENBURG FUN 6009 Harford	WERAL HOME,		21214		
	23. PART I. Enter the diseases, or con shock, or hear/fellure. Lis			t enter the mode of dying, so	ich aa cerdlec or reapl	ratory arrest,	Approximate		
	IMMEDIATE CAUSE (Final	1 /	A	1 541			Interval Between Onset and Death		
	disease or condition								
_	Interval Between Onset and Death Interval Between Onset and Death								
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A	CONSEQUENCE OF	7 1 1000 000			1095.		
ICA	cause. Enter UNDERLYING CAUSE (Disease or injury								
E	that initiated eventa resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF):						
	d						i		
AL	PART II. Other eignificent conditions of	ontributing to death bu	it not resulting in	the underlying cause given i	n Part I. 24s. WAS AN PERFOR		4b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO		
DIG					1 _ YES 2	₩ NO	OF DEATH?		
PHYSICIAN: MEDIC	DID TOBACCO USE CONTRIE	LITE TO CAUSE O	E DEATH VEC	D NO ELINGERTA			1 TYES 2 PE NO		
AN	25. WAS CASE REFERRED TO MEDICAL		8. PLACE OF DEATH		IN L				
Sic		IOSPITAL:		OTHER:	8 Other (Specify)				
E	27. MANNER OF DEATH	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME	OF 28c. INJURY AT	28d. DESCRIBE HOW II	NJURY OCCURED			
BY	1 Natural 5 Pending 2 Accident Investigation			M 1 YES 2 NO					
3 Suicide 8 Could not ba determined 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28t. LOCATION (Street and Number or Rural Route City or Town, Street)							el Route Number,		
COMPLET	29a. CERTIFIER 1 CERTIFYINO PHYSICIA	N: To the best of my knowle	edge, death occurred	at the time, date end place, end de	ue to the cause(e) and man	ner se stated.			
OM				In my opinion, death occured at the			e(e) end manner se stated.		
BE C	296. SIGNATURE AND TITLE OF CERTIFIER	2 (2)		29c. LICENSE N	UMBER	29d. DATE SIGN	ED (Month, Day, Year)		
TO	15 CK	exha	n	MD DI	6960	> //-	6-95		
	30. NAME AND ADDRESS OF PERSON WHO C	OMPLETED CAUSE OF DEA	TH (ITEM 27) (Types, P	The DV. RO, 1	Be Himor	e m	121221		
	NOV 0 91995	-32 REGISTRAR'S SIGNA	TURE			, , , , ,			

2, 3 should

STATE REGISTRAR

CARMELA

4. SOCIAL SECURITY NUMBER

102-24-3444

Maruland

10e. STREET AND NUMBER

3 Widowed 4 Divorced

Elementery/Secondery (0-12)

Mary Marin-

20e. METHOD OF DISPOSITION

IMMEDIATE CAUSE (Finel disease or condition

Sequentially liet conditiona,

if any, lasding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury

resulting in death)

that initiated events

27. MANNER OF DEATH

1 Netural

2 Accident

3 Suicide

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UTIL MONTHAL OF ALL ENDING FILLSIONNES THE TOTAL THE TOTAL OF CHANGE OF CHANGE OF THE TOTAL OF T	TOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlat-transit permit. Pages 1, 2, 3 after this call has been signed by the attending physician and Mental Hygiene prior to burlat, cremation, or removal.	28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	TO BE COMPLETED BY FUNERAL DIRECTOR
TO THE HOSPITAL OR ATTENDING PHYSICA	TO THE FUNERAL DIRECTOR: After this cert be filed within 72 hours after death with the	IMPORTANT: If Item 28 Is marked, o	TO BE COMPLETED BY PHY

95 33812 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Oct 29 1995 10:15 pm M **ACAMPA** 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS 70 1 M 2 K F Nov. 27, Se. FACILITY NAME (If not institution, give street end number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Baltimore Towson, Maryland Saint Joseph Medical Center RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Baltimore TY YES 2 NO 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 2806 E. Northern Parkway 21214 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. ORCES? 1 YES 2 YES, GIVE WAR OR DATES 1 X Never Merried 2 Merried specing White 1 YES 2 X NO Specify 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest ive kind of work done Do NOT use retired.) College (1-4 or 5+) 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surneme) 19a, INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2804 East Northern Parkway-Baltimore, Maryland 21214 20c. LOCATION — City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of 20s. METHOD OF DISPOSITION

1 Buriel 2 Cremetion 3 Removal from State

4X Donation 5 Other (Specify) SIGNAFIME OF SINERAL SERVICE LICENSEE Ranald Wade. Dir. 22. NAME AND ADDRESS OF FACILITY State Anatomy Board-655 W. Baltimore Street Rm. B026-Baltimore, Maryland 21201-1559 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Interval Between **Onset and Dasth** S YEARS HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR

DUE TO (OR AS A CONSEQUENCE OF): DISEASE

DUE TO (OR AS A CONSEQUENCE OF):

CHRONIC GASTRO INTESTINAL BLEEDING

DUE TO (OR AS A CONSEQUENCE OF):

PERIPHERAL VASCULAR DISEASE

24s. WAS AN AUTOPSY PERFORMEO?

24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO

5 YEARS

5 YEARS

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN

PART ii. Other significant conditions contributing to death but not resulting in the underlying ceuee given in Part i.

25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? HOSPITAL:
1 | Thoritent 2 | ER/Outpatient 3 | DOA OTHER: 4 - Nursing Home 5 - Residence 8 - Other (Specify)

28e. DATE OF INJURY

28b. TIME OF

28c. INJURY AT WORK? 1 YES 2 ND 28e. PLACE OF INJURY -- Al home, ferm, street, fectory, office

28d, DESCRIBE HOW INJURY OCCURED

281. LOCATION (Street end Number or Rural Route Number, City or Town, State)

1 YES 2 THO

29e. CERTIFIER 1 Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end menner as stated. 2 MEDICAL EXAMINER: On the basis of exemination end/or investigation, in my opinion, death occured at the time, date end place, and due to the cause(e) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER mod cl Mehla

29c. LICENSE NUMBER D41410

29d. DATE SIGNED (Month, Day, Year 10-30-95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

JOGÍNDÉR P. MEHTA, M.D., ST. JOSEPH MED. CTR., 7620 YORK RD., TOWSON, MD. 21204

31. DATE FILED (Month, Day, Year) NOV 09 18

5 Pending

8 Could not be determined

Investigation

32. MEGISTRIPS SIGNATURES
JULIA DRUBLOR RANGEL

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BALTIMORE, MARYLAND 21215-0020

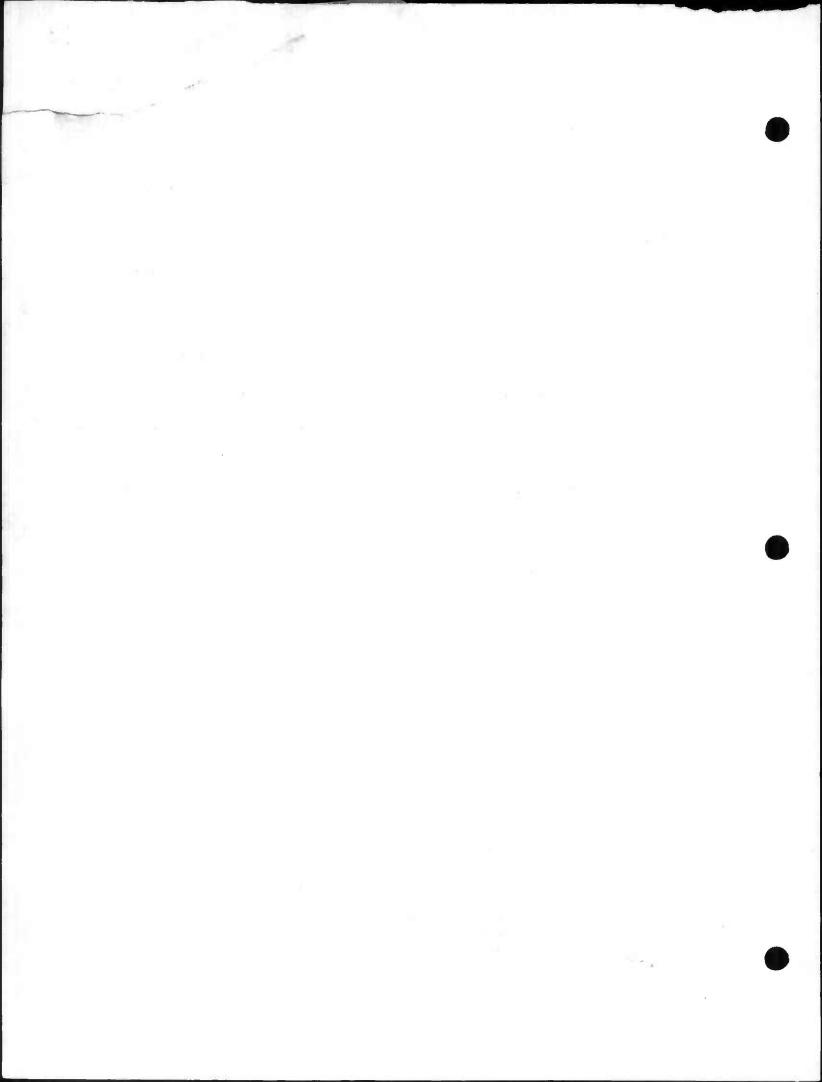
DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CE	RTIF	ICATE O	F DEATH	RE	G. NO.		
	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF DE			3. TIME OF DEATH
	Howard Lonz	o Ander	son				NOV. 7	, 1995	YEAR	6 A.
	4. SOCIAL SECURITY NUMBER	5. SEX	8. AGE (In yrs. las	t birthday)	IF UNDER 1 YEA	R IF UNDER 24 HRS.	7. DATE OF BU	RTH	8. BIRT	THPLACE (State or Foreign
	411 50 4847	iX[XM 2 □ F	61	YAS.	MONTHS DAY	S HOURS MIN.	June 2	6 , 1934	Te	nn.
nc	9a. FACILITY NAME (If not institution, give a	*				N OR LOCATION OF D	EATH	1	ounty of	
DIRECTOR	7543 Norwood Av	e.			Зу	kesville			11101	T
EC.	10e. STATE 10b. COUNT	Y		10c. CIT	Y, TOWN OR LO	CATION				10d. INSIDE CITY LIMITS?
	Md.	Carrol	L			Sykesvill	е			1 X YES 2 NO
AL	10e. STREET AND NUMBER					101. ZIP CODE		10g. (CITIZEN OF	WHAT COUNTRY?
FUNERAL	7543 Norwood Av					21784		Ţ	J.S.A	
٦	11. MARITAL STATUS	12. WAS DECEDENT	T EVER IN U.S. AR		13. WAS	DECENDENT OF HISPA , specify Cuban, Maxic	NIC ORIGIN? (Spi	ecify Yes or No-	- 14. RAC	CE — American Indian, ick, White, etc.
BY	1 Never Married 2 Married 3 Never Married 4 Divorced	IF YES, GIVE W				res 2 X NO Speci		With f	1	icity:
ED	15. DECEDENT'S EDU (Specify only highest grade	CATION .			USUAL OCCUP		16b. KIND	OF BUSINESS		
E	Elementary/Secondary (0-12)	College (1-4 or 5 +	life	Do NOT u	se retired.)	most of working				
MPL	10	_	I	oade	r Oper	ator		Genstai	r	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)						AME (First, Middle,	Maiden Sumam	•)	
BE	Marshall A	nderson					Bennie	?		
10	19a. INFORMANT'S NAME (Type/Print)		.19	b. MAILING		net and Number or Rural				
	Bobbie Sue Abert	3								Md. 21787
	20a. METHOD OF DISPOSITION 1 XBurlai 2 Cremation 3 Rem	noval from State			OF DISPOSITION	etery 1	DATE	20c. LOCATION	— City or 1	Fown, State
	4 Donation 6 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE Li	CENSEF	Sprin	igt 1e	eld Cem	etery L	T/T0/93	Sykes	VILLE	, Ma.
	+ Horan TV.	Hairt	+		P.0	Box 195	aight Sykesvi	Funeral	L Hom d. 21	e .784
-	23. PART i. Enter the diseases, or	complications the	t caused the de	ath. Do	not enter the	mode of dying, su	ch as cardiac d	or reapiratory	arrest,	Approximata
	ahock, of heart feilure.	List only whe cau	se on each iine).		ay on				Interval Between Onset and Dear
	resulting in death)	DUE TO	(OR AS A CONSE	DUENCE-O	F):	d				
z		ch.	ALI	M	Shism	~				
CERTIFICATION	if any, leading to immediate	DUE TO	(OR AS A CONSE	DUENCE O	F):					
CA	cause. Enter UNDERLYING CAUSE (Disease or injury		erter							
TIF	thet initiated events	e h	(OR AS A CONSE	DUENCE O	nent					
Ë		d (UN	-		~~~~	-				
	PART ii. Other aignificant condition			eauiting	in the under	ying cause given is	Part i. 24e.	WAS AN AUTOP	SY 24	4b. WERE AUTOPSY FINDING
DICAL	Don Com	Mian	r .			1770		PERFORMED?	,	AWAILABLE PRIOR TO COMPLETION OF CAUSE
MED								3 (3)		OF DEATH?
	DID TOBACCO USE CONT	RIBUTE TO CA	USE OF DEA	TH Y	ES NO	UNCERTA	IN 🗹			
CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	28. PLAC	CE OF DEA	TH (Check only	one)				
PHYSICIAN:	1 [] YES 2 [] NO	1 Inpatient 2				Home 5 Residence	8 C Other (Spe	icify)		
H	27. MANNER OF DEATH 1 ☑ Natural 5 ☐ Pending	28e. DATE OF (Month, D		28b. TIN	JURY	INJURY AT WORK?	28d. DESCRIB	E HOW INJURY	OCCURED	
BY	2 Accident Investigation					YES 2 NO				
COMPLETED	3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE O building,	F INJURY — At ho etc. (Specify)	eme, tarm,	streat, factory,	offica	281. LOCATION City or Tox	(Street and Nun vn, State)	nber or Rura	I Route Number,
ř	290. CERTIFIER 1 CERTIFYING PHYS	SICIAN: To the best of	my knowledge, de	ath occur	red at the time.	data and place, and du	is to the cause(s)	and manner as	stated	
) MIF										e(a) and manner ae stated.
	29b. SIGNATURE AND TITLE OF CERTIFIE					29c. LICENSE NO				ED (Month, Day, Year)
H	Shounda &	ilain	Ms			D301		290.	1118	3195
5	30. NAME AND ADDRESS OF PERSON WI	10 COMPLETED CAU			a, Print)					
	SHAHIDA S	IDDIOI	6	212	- 2	1 KEZNI	LLE 1	201	217	84
0	NOVO 91985	garage and the second	मुख्यार प्राप्त	4						



Addones

1 - STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

sight dept

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

Juan Scott Adams

2. DATE OF DEATH MONTH

november

1995

3. TIME OF DEATH

9:30 PM

Approximata

Onset and Death

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DIVISION OF VILAL RECORDS, P.O. BOX 68760	0
_	HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. P
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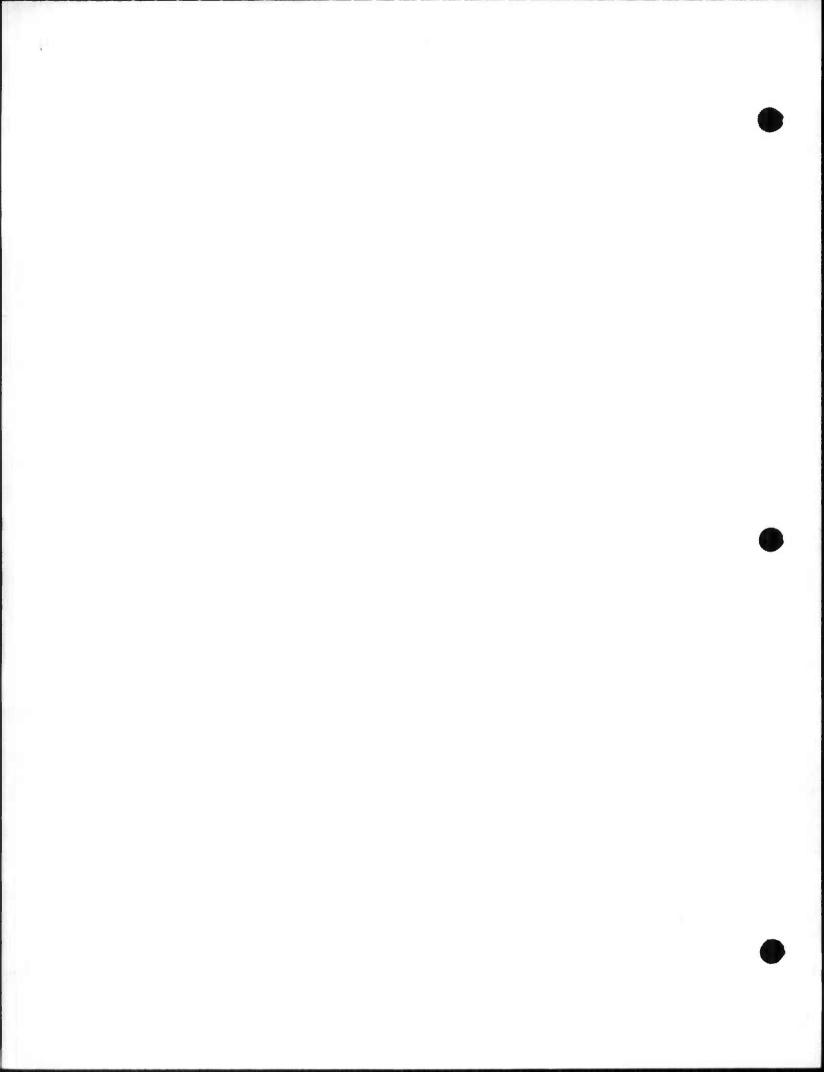
4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. lest birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign JAN 17, 1959 211-52-9226 DAYS HOURS 1X M 2 | F Pennsylvania Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street end number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Johns Hopkins Bay View Baltimore N/A RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland N/A Baltimore 1 X YES 2 NO permit. 10e. STREET AND NUMBER FUNERAL 10g. CITIZEN OF WHAT COUNTRY? 480 Crowson Avenue be detached for use as the burial-transit 21217 USA retained by the hospital or attending physician. 11, MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—if yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE - American Indian, Black, White, etc. Never Married 2 Merried Specify: Black BY 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highe Elementary/Secondary (0-12) College (1-4 or 5+) Designer Clothing Industry 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname To Willie James Adams Florence Edna Williams BE page 5 should notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Flural Route Number, City or Town, State, Zip Code) 2 Cheryl Lynn Adams 124 Coalpit Hill Rd. #99 Danbury, CT 06810 2 20a. METHOD OF DISPOSITION
1 Burlel 2 A Cremation 3 Rem 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State must director, detro Crematory, Inc. 11/9/95 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE DAWN F. Baltimore, MD 30e 22 NAME AND ADDRESS OF FACILITY Cremation Society of Maryland, Inc. examiner funeral ,McDonald 299 Frederick Rd. Baltimore, MD 21228 the medicai 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, in by shock, or heart failure. List only one cause on each line. 8 filled IMMEDIATE CAUSE (Final the cremation, Facture disease or condition Renal pletely event, resulting in death) DUE TO (OR AS A CONSEQUENCE OF): and com retroviral syndrome traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): 9 If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury the attending phy 1 Mental Hygiene p or other DUE TO (OR AS A CONSEQUENCE OF): that initiated eventa resulting in deeth) LAST PART II. Other algorificent conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS and an AVAILABLE PRIOR TO COMPLETION OF CAUSE shows any Signed Health a 1 YES 2 NO OF DEATH? 1 YES 2 NO been . DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: has b Dept. 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) item certificate I HOSPITAL: OTHER:
4 15 Nursing Home 5 - Residence 6 - Other (Specify) 1 YES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 6 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? marked, 28d. DESCRIBE HOW INJURY OCCURED this 1 Natural 5 Pending М 1 YES 2 NO BY After 1 investigation 2 Accident 26e. PLACE OF INJURY — At home, farm, street, fectory, office building, etc. (Specify) 3 Suicide .00 281. LOCATION (Street end Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be DIRECTOR: hours after 4 Homicide 28 determined 29a. CERTIFIER (Check only one)

29 MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, data end place, end due to the cause(e) and manner as atsted. FUNERAL within 72 h = TO THE HOSPITA
TO THE FUNERAL
De filed within 72
IMPORTANT: II 2 ___ MEDICAL EXAMINER: On the beele of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and menner ea attend. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE 29d, DATE SIGNED (Month, Day, Year) land N3807 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (FIDE. PHINT)

K. OILVSIET MD Johns Hopkins Boyviau Medical Center
K. OILVSIET MD 5200 Eastern AVE Balto, MD ZI 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE NOV 09 1994

DHMH-16 Rev 1/89



Pages 1, 2, 3 should

BE

2

30. NAME AND ADDRESS OF

31. DATE PILED (Month, Day, Year)

Item18 11-9-95 FilmG729 W.H.Per F/H FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH DAY 3 TIME OF DEATH NOVEMBER 6,1995 CEIL BRUTZKUS 11:19pm 4. SOCIAL SECURITY NUMBER 6. AGE (in yrs. lest birthday) 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS 216-01-3096 1 - M 2 - F NOV. 8,1913 MARYLAND 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR SINAI HOSPITAL BALTIMORE N/A 10a. STATE 10b. COUNTY 10c CITY TOWN OR LOCATION 10d. INSIDE CITY BALTIMORE 1 XYES 2 NO MARYLAND N/A FUNERAL 10g. CITIZEN OF WHAT COUNTRY? 10e. STREET AND NUMBER 10f. ZIP CODE 3818 FORDS LANE, APT. 104 21215 USA 12. WAS DECEDENT EVER IN U.S. ARMEO FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS OECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—
If yes, specify Cuben, Maxican, Puerto Rican, atc.)

1 YES 2 NO Specify: 11. MARITAL STATUS 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 X Married BY 3 Widowed 4 Divorced WHITE ETED 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15 OFCEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only hi Elementary/Secondary (0-12) College (1-4 or 5+) COMPL 12 CLERK CITY OF BALTIMORE 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) **JACOB** ROSENBERG SHAPIRO DEBORAH BE Devorah 19a, INFORMANT'S NAME (Type/Print) 19b. MAILING ADORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code, 2 MR. LESTER 3818 FORDS LANE, APT. 104 BALTIMORE, MD 21215 **BRUTZKUS** 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, Stata Burial 2 Cremation 3 Removal from State BETH JACOB Donation 5 Other (Specify) 11-8-1995 FINKSBURG, MD SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 26 6010 REISTERSTOWN ROAD BALTIMORE, MD 21215 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximata Interval Between Onset and Death IMMEDIATE CAUSE (Fine) disesse or condition_ 4-100 Acorpe Darchellian. reaulting in death) DUE TO (OR AS A CONSEQUENCE OF): Coronary Artery Disease DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART ii. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part i. 24a, WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL PERFORMED? AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 | YES 2 | NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 26. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL HOSPITAL: OTHER:
4 Nursing Home 5 Residence 8 Other (Specify) 1 YES 2 TINO 1 Minpetient 2 - ER/Outpetient 3 - DOA 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 286. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natoral 5 Pending Investigation 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, farm, streat, factory, office building, atc. (Specify) 3 Sulcide 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) ETED. 8 Could not be 4 Homicide 29a. CERTIFIER

(Chack only 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(a) and manner ea stated. COMPL 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner os stated. 29b. SIGNATURE AND TITLE OF CERTIFIER

Vasaer,

GLASSON -

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ERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

wy/worker

2011200000 32. REGISTRAR'S SIGNATURE Drivilson Rang

29c. LICENSE NUMBER

8.04/2

29d. DATE SIGNED (Month, Day, Yber)

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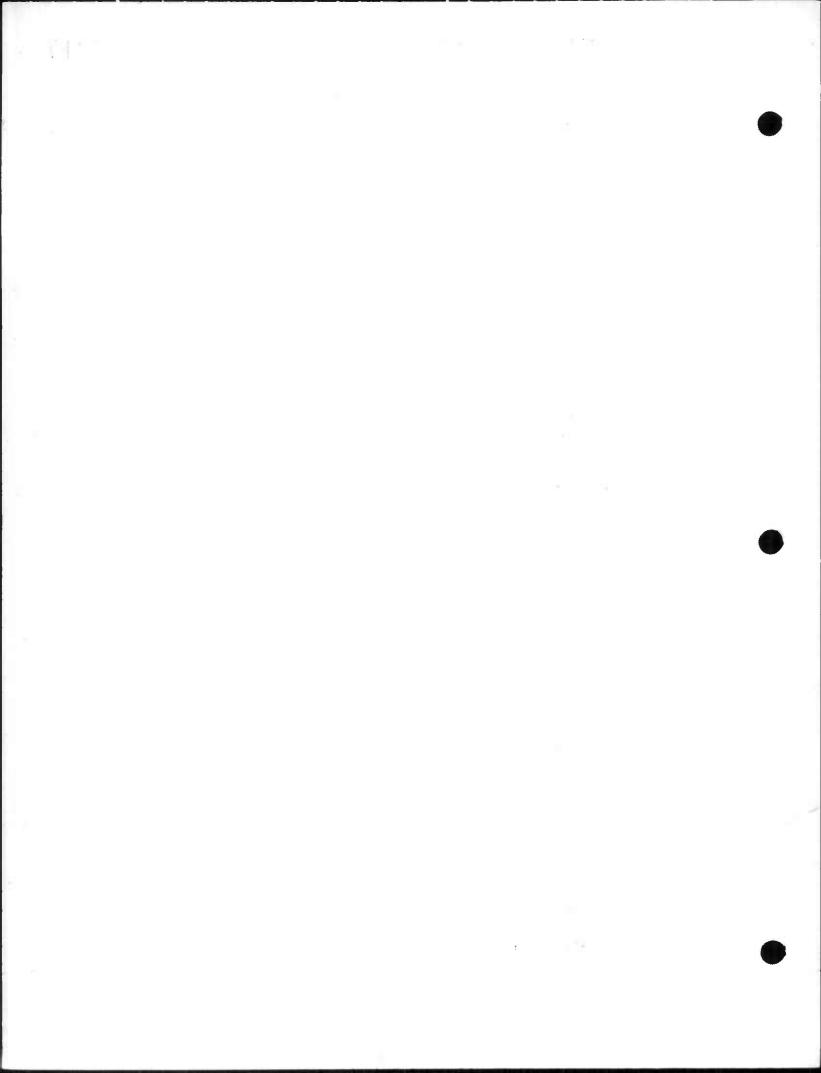
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the host TO THE FUNERAL DIRECTION. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache be filled within 72 hours after death with the State Dept. of Health and Merital Hyghers prior to burial, certaining, or enforce, or enforce, or learn 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1	1-19	Rita Jen			H 十				2. DATE (REG. NO		YEAR 19	3. TIME OF DEATH
4. SOCIAL SECURITY NU		5. SEX	6. AGE (In yrs. It		IF UNDER	1 YEAR DAYS	HOURS	R 24 HRS.		Day, Year)		Count	HPLACE (State or Foreign Iny)
218-14-163		1 M 2 F	12	YRS.						22-			laryland
9a. FACILITY NAME (# no		street and number)			10-14			TON OF D	EATH		9c. COU	NTY OF [DEATH
Mercy Hospital RESIDENCE OF DECEDENT						timo	re	_					
10a. STATE	10c. CIT	Y, TOWN O	A LOCA	TION						10d. INSIDE CITY LIMITS?			
Maryland				B	altir	nore	2						1X YES 2 NO
601 Reserv	oir St	reet				101	212	217		10g. CITIZEI U.S.			WHAT COUNTRY?
11, MARITAL STATUS 1 Never Married 2 3 Wildowed 4 D	T EVER IN U.S. A YES 2 X AR OR DATES		- 11	yes, sp	ecify Cub		in, Puarto R	? (Specify Ye Ican, atc.)	s or No—	Blec	E — American Indian, ok, White, alc. ony: White		
	ECEDENT'S EDU		16a, D	ECEDENT'S Give kind of a fe. Do NOT as	USUAL OC	CUPATIO	DN ost of work	ting	16b.	KIND OF BU	ISINESS/IN	DUSTRY	
Elementery/Secondary	y (0-12)	College (1-4 or 5	.)								ad Na	+ 1 00	al Paul
12 17, FATHER'S NAME (First)			A	ecoun	us ro	ayat	_					L & O V	ial Bank
Edward Jeu	nette						Ma	rie (Gray	liddle, Maider			
Paul D. Be		sonj								or, City or Tou (MOTE			nd 21217
20a. METHOD OF DISPOS 1 G Burial 2 G Creme 1 Donation 5 G Ott	ation 3 🗆 Ren	noval from State		EAND DATE		ITION (N	ame of		DATE	20c. L0	OCATION -	City or T	own, State
		. List only one cau	t caused the dise on each lin		-					400			201-1559 Approximate
ahock, or immediate Cause (disease or condition resulting in death) Sequentially list conif any, leading to immediate. Enter UNDER CAUSE (Disease or I that initiated events	ditions, mediate LYING njury	a. DUE TO	e on each life	EOUENCE O	not enter					400			Approximate Interval Between
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ahock, of IMMEDIATE CAUSE (disease or condition resulting in death) Sequentially list conif any, leading to impose the control of the contro	ditions, mediate LYING njury AST USE CON' D TO MEDICAL Pending investigation Could not be determined	a. DUE TO b. DUE TO c. DUE TO d. TRIBUTE TO CA HOBPITAL: 1 Inpatient 2 28a. PLACE 6 building	(OR AS A CONS (OR AS	EOUENCE O EOUENCE O EOUENCE O EOUENCE O Tresulting ATH YI ACE OF DEA 28b. Till IN death occurred	In the un ES	NO DE STATE OF THE	g cause UN The 5 I TORKY YES 2	glven in CERTAI	Part I. Other 26d. LOC. City of the cause to the cause	24a. WAS AL PERFC 1 YES T (Specify) CRIBE HOW ATION (Street) TOWN, Steh	N AUTOPSY PRMED? 2 NO INJURY OC.	24 CCURED or or Rural	Approximate Interval Betwee Onset and Dea Dea Dea Dea Dea Dea Dea Dea Dea Dea

BALTIMORE, MARYLAND 21215-0020	ie law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 s Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
	24 hor	filled on, or
AL RECORDS, P.O. BOX 68760	ie law requires that the death certificate be executed within 24	has been signed by the attending physician and completely filled in by the Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

		1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPAR CERTIF	RTMENT OF H	HEALTH AND	MENTAL HYGIE REG. N					
		1. DECEDENT'S NAME (First, Middle, Last)	- J. B	1417	ret Juli	a Britt	2. DATE OF DEATH MONTH NOV &	DAY 188	S 04.45 M			
Pin		4. SOCIAL SECURITY NUMBER 158-09-9772	1 🗆 M 2 🔯 🕝 7	(In yrs. last birthday) 73 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	AUG. 8, I)22 N	BIRTHPLACE (State or Foreign Country) Jersey			
1, 2, 3 should	TOR	so. FACILITY NAME (If not institution, give s Good Samaritan Ho			Baltin	OR LOCATION OF DI	EATH	N/A	Y OF DEATN			
Pages	DIRECTOR	Maryland Balti		10c. CIT	Y, TOWN OR LOCA	Baltimo	ore		10d. INSIDE CITY LIMITS? 1 YES A NO			
n. ansit permit.	FUNERAL	6401 Loch Raven I	31vd., Apt. 3	306	10	2123	9		N OF WHAT COUNTRY?			
5-UUZU inding physician. as the burial-transit	BY	11, MARITAL STATUS 1 Never Merried 2 Merried 32 Widowed 4 Divorced	12. WAS DECEDENT EVER II FORCES? 1 YES IF YES, GIVE WAR OR D	2X NO	If yes, sp	CENDENT OF HISPAI ecity Cuban, Mexica 3 2 A NO Specifi	NIC ORIGIN? (Specify Y in, Puerto Rican, etc.) y:	es or No- 14	Black, White, etc. Specify: White			
Z 1 Z 1 al or atte for use	PLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)		16a. DECEDENT'S (Give kind of life. Do NOT u		ON ost of working	OWN HOT	USINESS/INDUS	тяу			
3 8 6 E	Ш	17. FATHER'S NAME (First, Milodie, Last) Stephen Bok		220mesnes			ME (First, Middle, Meide Helen Lis	on Sumame)				
ay be retained page 5 should be notified	TO B	190. INFORMANT'S NAME (Type/Print) Anita L. Britt		19b. MAILING 6401	ADDRESS (Street of Loch Ray)	en Blvd.	Route Number, City or To , Apt. 306	wn, Stein, Zip Co 5 Balti	more, MD 21239			
rector,		20a. METNOD OF DISPOSITION 1	oval from State	PLACE AND DATE	atory, I	nc. 11/	09/95 Ba		e, MD			
		21. SIGNATURE OF TOWERAL SERVICE LICENSE. George E. MacNabb 22. NAME AND ADDRESS OF FACILITY CREMETION Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate										
ted within 24 hours after of completely filled in by the rial, cremation, or removal.		immediate cause (Final disease or condition resulting in death)	e. Abdowi	ech line.	chem	ede of dying, suc	h ss cardiac or rea	piratory arrest	t, Approximata Interval Batween Onset and Death Weeleg			
be executed sician and con rior to burial, traumattic en	CATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	Carlina	CONSEQUENCE	01				Days			
ending a state of other	CERTIFI	that initiated events resulting in death) LAST	DUE YO (OR AS A	consequence o	nsian)			Yeers			
at the d by the and Me	MEDICAL (PART II. Other aignificent condition	e contributing to deeth b	ut not resulting	in the underlying	g ceuse given in	Pert i. 24a. WAS A PERFC	IN AUTOPSY DRMED?	24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?			
23 Pept	HAN: N	DID TOBACCO USE CONTE		F DEATH YE		UNCERTAIN	12		1 TES 2 NO			
PHYSICIAN: The this certificate h with the State (PHYSICIAN:	EXAMINER? 1 YES 2 HO 27. MANNER OF DEATH	HOSPITAL: 1 Impetient 2 ER/Outp 28s. DATE OF INJURY	patient 3 DOA		e 5 Residence						
PHY this this	BY PI	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJ	M 1 1	PRK? YES 2 NO	28d. DESCRIBE NOW	INJURY OCCUR	leO			
ATTENDI ECTOR: A s after d	ETED	3 Suicide 6 Could not be 4 Homicide determined	28s. PLACE OF INJURY building, etc. (Spec	— At home, tarm, soily)	street, factory, office		28t. LOCATION (Street City or Town, Stett	snd Number or i	Rural Route Number,			
型型に =	COMPLE		CIAN: To the best of my knowledge. On the basis of examination						ause(s) and menner se stated.			
TO THE HOSPI TO THE FUNEF be filed within	TO BE	296. SIGNATURA AND TURE OF CONTIFIER	~ M.D			D47	10 14	29d. DATE SI	IGNED (Month, Day, Year) OV 11, 1995			
	ř	A. JANECI	COMPLETED CAUSE OF DE	ATH (ITEM 27) (Type,	1	Hospi	tol, Bo	ett un	ap			
		31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGN		T	-						



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	1 - STATE REGISTRAR		STATE OF I	MARYLAN	ID / DEPAR	TMENT OF	HEALTH F DEAT	AND N	MENTAL HYGIEN REG. NO.	E		
	1. DECEDENT'S NAME (First,				_				2. DATE OF DEATH MONTH DA		YEAR	3. TIME OF DEATN
			M. B.	ALLE!	<u> </u>				NOU 6		795	8:20 PM
	4. SOCIAL SECURITY NUMB	ER	S. SEX	6. AGE (In y	rs. last birthday)	IF UNDER 1 YEA	-		7. DATE OF BIRTH (Month, Day, Year)		8. BIRTH Countr	PLACE (State or Foreign
	216-36-0060		1 🔀 M 2 🗌 F	58	YRS.	MONTHS DAY	B HOURS	MIN.	MAY 6, 193	7		" RYLAND
	9a. FACILITY NAME (If not ins					9b. CITY, TOW	N OR LOCATIO	ON OF DE			NTY OF D	
5	ST. AGNES HO		L			BA	TIMOR	E		BA	LTIM	ORE CITY
5	RESIDENCE OF DEC	10b. COUNT	,		40- 077							
DIRECTO	MARYLAND		NE ARUND	ET		TOWN OR LO		IIma				10d. INSIDE CITY LIMITS?
_	10a. STREET AND NUMBER	All	NE AROND	EL	111	NTHICU	1 HELG	_				1 TES 2 X NO
	711 ANDOVER	ROAD										HAT COUNTRY?
LONGHAL	11. MARITAL STATUS	ROAD	12. WAS DECEDEN	T EVED IN II	S ABMED	42 1170	210	, ,	C ORIGIN? (Specify Yes		S.A.	
	1 Never Married 2 💢	Married	FORCES?	YES 2	2 X NO	If yes,	specify Cuber	n, Mexican	, Puerto Rican, etc.)	or No-	Black	— American Indian, White, atc.
0	3 Widowed 4 Divor	ced	IF YES, GIVE Y	MAH OR DATE:	S	101	ES 2 NO	Specify:			Speci	WHITE
3	15. DECE	DENT'S EDU	CATION	16	a. DECEDENT'S	USUAL OCCUP	ATION		16b. KIND OF BUS	INESS/IND		
COMPLE	Elementary/Secondary (0-		College (1-4 or 5	+)	life. Do NOT us	ork done during retired.)	most of working	g	EARL W.	RAII	ומ סק	ITI DEDC
	H/S GRAD				CARPENT	ΓER			BILLE W.	DAU.	EK D	OILDEKS
5	17. FATNER'S NAME (First, Mile						18. MOTH	IER'S NAM	NE (First, Middle, Malden	Sumame)		
2	EARL W. BAU	IER					BI	ESSI	E TAYLOR			
	19a. INFORMANT'S NAME (Ty				19b. MAILING	ADDRESS (Stre	et and Number	or Aural A	oute Number, City or Town	, State, Zip	Code)	
	M. DARLENE B	AUER			711 A	NDOVER	ROAD -	- LIN	THICUM HE	IGHT	s, M	21090
	20a. METNOD OF OISPOSITIO		mml from State		ACE AND DATE O	F DISPOSITION	(Name of			CATION -		
Į	4 Donation S Other	(Specify)		LAK	EVIEW N	IEMORI <i>A</i>	L PARE	ζ	11/9 SYK	ESVI	LLE	
	21. SIGNATURE OF PUNERAL	SERVICE LIC	ENSEE	4	2		AND ADDRES		ILITY			
- 1	1 Your	: (Sil	11					AL HOME, I			
7	23. PART I. Enter the dis	seases, or c	omplications the	t caused th	a death. Do n	of enter the	mode of dvi	ng, such	AVENUE - B	ALTII	TOKE.	MD 21229
	anock, or ne	art fellure.	List only one ceu	ise on each	line.		,				2	Intarval Between
- 1	IMMEDIATE CAUSE (Find disease or condition		ACL	ITE	Mila	2181	7 A 1		FA DAF			Onset and Death
ļ	resulting in death)		DUE TO	(OR AS A CO	INSEQUENCE OF	141015	774 _	1 1	FARCT			2 days
.									DISEAS	Œ		3-400
2	Sequentially list condition if any, leading to immed		OUE TO	(OR AS A CO	NSEQUENCE OF):	0,0	J	3.4077			1 - 7
5	cause. Enter UNDERLYIN CAUSE (Disease or Injur	VG										
	that initiated events	1	DUE TO	(OR AS A CO	NSEQUENCE OF):						
3	resulting in deeth) LAST		1									
		-										
	PART II. Other significer	at condition	s contributing to	death but a	not considered to	allo condinate	dan anima a	tore to P	ar I a min			
2	PART II. Other significer						ing ceuse g	iven in F	Part I. 24s. WAS AND PERFOR		24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
מיסוק	CEREBRO	OVAS	CULA	R	ACCE'S	ENT		iven in F		MEO?	24b.	
	CHRON	OVAS	REN	RIAL	ACCEN	ENT	E		PERFOR	MEO?	24b.	AVAILABLE PRIOR TO COMPLETION OF CAUSE
ANT. INCIDIORE OF	CEREBRO CHRONI DID TOBACCO US	OVAS (CC)	REN	R AL JUSE OF I	ACCES FA	ENT CUR S NO	UNC		PERFOR	MEO?	24b.	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
DICAL C	CEREBRO CHRON DID TOBACCO US 25. WAS CASE REFERRED TO EXAMINER?	OVAS (CC)	RIBUTE TO CA	USE OF E	DEATH YE	EXIT CUR NO H (Check only o	UNC	ERTAIN	PERFOR	MEO?	24b.	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
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מיסוק	CERBRE CHRON DID TOBACCO US 25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 NO 27. MANNER OF DEATN	OVAS (CC)	RIBUTE TO CA	USE OF E	DEATH YE	S NO H (Check only o OTHER: 4 Nursing N OF 28c. HY	UNCI	ERTAIN	PERFOR	MEO?		AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
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מיסוק	CF ROAD CF ROAD DID TOBACCO US 25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 NO 27. MANNER OF DEATN 1 Netural 5 P 2 Accident 3 Suicide 8 C	OVAS (C) C SE CONTI MEDICAL	RIBUTE TO CA HOSPITAL: 1 Propertient 2 [28a. DATE OF (Month, D) 28a. PLACE O	USE OF E 26. ER/Outpatie INJURY ay, Year)	DEATH YE PLACE OF OEAT OT 3 DOA 280. TIME	S NO H (Check only o OTHER: 4 Norning N OF IRY M 1 [UNCI	ERTAIN	PERFOR 1 YES 2	MEO?	CURED	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
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מיסוק	CF ROAD CF ROAD CF ROAD DID TOBACCO US 25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 NO 27. MANNER OF DEATN 1 Netural 5 P 2 Accident 3 Sulcide 4 Nomicide 4 Nomicide 6 29a. CERTIFIER (Check only one) 2 MEDIC	SE CONTIL MEDICAL Anding Investigation Could not be etermined FYING PHYSIC CAL EXAMINE	RIBUTE TO CA HOSPITAL: 1 Propertient 2 28a. PLACE Of building. CIAN: To the best of R: On the best of e	USE OF [26. ER/Outpatie INJURY ay, Year) FINJURY my knowledg	DEATH YE PLACE OF OEAT TM 3 DOA 28b. TIME INJU At home, term, step, death occurre	S NO N (Check only o OTHER: 4 Nursing h OF 28c. JIPY M 1 Irrest, tectory, o	UNCI	ERTAIN aldence 8 NO end due t	PERFOR 1 YES 2 Other (Specify) 28d. OESCRIBE NOW IN City or Town, Stele)	JURY OCC	or Rural A	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
מיסוק	CF ROAD CF ROAD CF ROAD DID TOBACCO US 25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 NO 27. MANNER OF DEATN 1 Natural 5 P ROAD 2 Accident II 3 Sulcide 8 C C Accident II 4 Nomicide C Death 29a. CERTIFIER (Check only)	SE CONTIL MEDICAL Anding Investigation Could not be etermined FYING PHYSIC CAL EXAMINE	RIBUTE TO CA HOSPITAL: 1 Propertient 2 28a. DATE OF (Month, D) 28a. PLACE O building. CIAN: To the best of R: On the basis of e	USE OF [26. ER/Outpatie INJURY ay, Year) FINJURY my knowledg	DEATH YE PLACE OF OEAT TM 3 DOA 28b. TIME INJU At home, term, step, death occurre	S NO N (Check only o OTHER: 4 Nursing h OF 28c. JIPY M 1 Irrest, tectory, o	UNC! Orne 5 Rest INJURY AT WORK? YES 2 Wilce Wilce Asset and place, ,, death occure	ERTAIN aldence 6 No end due t end at the ti	PERFOR 1 YES 2 Other (Specify) 28d. OESCRIBE NOW IN City or Town, Stete) the cause(a) and men ime, data and place, and	MEO? NO NO NO NO NO NO NO NO NO NO NO NO NO	or Rural R	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
	CFURDA CFURDA CFURDA CFURDA DID TOBACCO US 25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 NO 27. MANNER OF DEATN 1 Natural 5 F 2 Accident It 3 Sulcide 8 C 4 Nomicide 6 29a. CERTIFIER (Check only one) 2 MEDIC 29b. SIGNATURE AND TITLE (Check only one) 1 CERTIFIER (Check only one) 2 MEDIC 29b. SIGNATURE AND TITLE (Check only one) 2 MEDIC	SE CONTI MEDICAL Medical UTE TO CA HOSPITAL: 1 Onpetient 2 E 28a. DATE Of (Month, D) 28a. PLACE O building. CIAN: To the best of e	USE OF [26. ER/Outpatie INJURY ay, Year) FINJURY my knowledg xamination an	DEATH YE PLACE OF OEAT TM 3 DOA 28b. TIME INJU At home, term, step, death occurre didor investigation	S NO N (Check only o OTHER: 4 Nursing h OFF Bry M 1 (creet, tectory, o d at the time, d i, in my opinion	UNC! Ome 5 Res INJURY AT WORK? YES 2 Iffice ate and place, I, death occure	ERTAIN aidence 6 No end due t ed at the ti	PERFOR 1 YES 2 Other (Specify) 28d. OESCRIBE NOW IN City or Town, Stete) the cause(a) and men ime, data and place, and	NO NO NO NO NO NO NO NO NO NO NO NO NO N	or Rural R	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Dute Number, and manner as stated.	
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DICAL C	CFURENCE CFU	SE CONTI MEDICAL Mending Men	RIBUTE TO CA HOSPITAL: 1 Onpetient 2 E 28a. DATE Of (Month, D) 28a. PLACE O building. CIAN: To the best of e	USE OF I 26. ER/Outpatie INJURY ay, Vear) FINJURY my knowledg xamination an	DEATH YE PLACE OF OEAT IT 3 DOA 28b. TIME At home, term, si e, death occurre d/or investigation (ITEM 27) (Type,	S NO H (Check only o OTHER: 4 Nursing h COF PRY M 1 Iteel, tectory, o	UNCI	ERTAIN aldence 6 No end due t end at the ti	PERFOR 1 YES 2 Color (Specify) 28d. DESCRIBE NOW IN 28t. LOCATION (Street a City or Town, Stete) to the cause(a) and men ime, data and place, and BER	NO NO NO NO NO NO NO NO NO NO NO NO NO N	or Rural R	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Oute Number, and manner as stated. (Month, Day, Year)
מיסוק	CFURDA CFURDA CFURDA CFURDA CFURDA DID TOBACCO US 25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 NO 27. MANNER OF DEATN 1 Natural 5 F 2 Accident II 3 Sulcide 8 C 4 Nomicide 6 29a. CERTIFIER (Check only one) 2 MEDIC 29b. SIGNATURE AND TITLE IN ITALIAN 30. NAME AND ADDRESS OF	SE CONTI MEDICAL Mending Men	RIBUTE TO CA HOSPITAL: 1 Department 2 28e. DATE OF (Month, D) 28e. PLACE O building. CIAN: To the best of e	USE OF I 26. ER/Outpatie INJURY ay, Vear) FINJURY my knowledg xamination an	DEATH YE PLACE OF OEAT 1 3 DOA 28b. TIME INJ. At home, term, si cle, death occurre dor investigation (ITEM 27) (Type,	S NO H (Check only o OTHER: 4 Nursing h COF PRY M 1 Iteel, tectory, o	UNCI	ERTAIN aldence 6 No end due t end at the ti	PERFOR 1 YES 2 Color (Specify) 28d. DESCRIBE NOW IN 28t. LOCATION (Street a City or Town, Stete) to the cause(a) and men ime, data and place, and BER	NO NO NO NO NO NO NO NO NO NO NO NO NO N	or Rural R	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Dute Number, and manner as stated. (Month, Day, Year) 6 1995

x1-5-seek

		1 - FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPARTM			MENTAL HYGIENE REG. NO.		
		1. DECEDENT'S NAME (First, Middle, Last) MINERV	A Dawn B	JRT			2. DATE OF DEATH MONTH DAY	1995	3. TIME OF DEATH
2		4. SOCIAL SECURITY NUMBER 219-16-5033	1 🗆 M 2 🔟 🔭		UNDER I YEAR OTHE DAYS	IF UNDER 24 HRS. HOURS. MIN.	7. DATE OF BRITTH (MONTH, Day, Mar)	8. BIRTH Gount	
2, 3 should	BY FUNERAL DIRECTOR	90. FACILITY NAME (If not Institution, give s JOHNS HOPKINS	GCRIATRICS	certer "		R LOCATION OF DE	E Citu	9c. COUNTY OF D	EATH
. Pages 1,		RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT Maryland	v Baltimore	10c. CITY, T	OWN OR LOCAT	ION	dalk		10d. INSIDE CITY LIMITS?
nsit permit.		100. STREET AND NUMBER 812 Mildred Ave			10f.	ZIP CODE	1222	10g. CITIZEN OF W	1 VES 2X NO VHAT COUNTRY? States
215-0020 attending physician. se as the burla-transit		11, MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES	2XXNO	13. WAS DEC	cify Cuben, Mexica	IIC ORIGIN? (Specify Yea or n, Puerto Rican, etc.)	r No — 14. RACE Black Speck	American Indian, c, White, atc.
Z7Z75-	ETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)		16a. DECEDENT'S USI (Give kind of work life. Do NOT use n	done during mos	N st of working	16b. KIND OF BUSIN		White
the hospital or detached for u	COMPL	12 Years 17. FATHER'S NAME (First, Middle, Last)		Shippin	g Cleri	18, MOTHER'S NA	Truc ME (First, Middle, Melden Su	ımame)	
retained by 5 should be notified at	띪	Frank Henry 180. INFORMANT'S NAME (Type/Print)		19b. MAILINO AD	DRESS (Street as		nma Saunder. House Number, City or Town,		
1 2 8 B	5	James R. Burt		812 Mi	ldred 1	Ave. Du	ndalk, Mary	land 21	1222
E e e		1 Surtal 2 Cremation 3 Ram 4 Donation 5 Other (Specify)	oval from Stata come	PLACE AND DATE OF D	emeter	y 11/10	/1995 Bal	timore,	Maryland
SAL r death he fune al.		Justinay	h. Llike		Duda- 1922	Wise Au	reral Home of	MD 21	
ely filled in the nation, or red		IMMEDIATE CAUSE (Final	s. Right Cores	ch line.				lory srrest,	Approximats Interval Between Onset and Death 2 Mounts
certificate be executed viding physician and corr Hygiene prior to buriat, or other traumatic every	ERTIFICATION	Sequentially list conditions, if any, leading to immediate	b. Sepsis Due to (or as a co	CONSEQUENCE OF):					DAYS DAYS
0 0 5 5	AL CE	PART II. Other significent condition	s contributing to death bu	t not resulting in t	he underlying	csuse given in	Part I. 24e. WAS AN AU	JTOPSY 24b.	WERE AUTOPSY FINDINGS
requires that the signed by of Health are shown any	MEDIC	Sh Subderal & Comercy ta, g DID TOBACCO USE CONTI	Hemoforia, Co M. Shectony	_		seficies	PERFORME 1 YES 2 S	NO	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
B B B	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		6. PLACE OF DEATH (UNCERTAIN	V 🔲]		
the the	PHYS	1 YES 2 NO 27. MANNED OF DEATH	1 Inpetient 2 ER/Outpet 28a. DATE OF INJURY (Month, Day, Year)		Nursing Home		6 Other (Specify) 28d. DEŞCRIBE HOW INJU	URY OCCURED	
After death	D BY	1 Netural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	28a. PLACE OF INJURY -	- At home, farm, stree	M 1 🗆 Y	ES 2 NO	281. LOCATION (Street and	Number or Rural R	oute Number,
OR ATTENG DIRECTOR: hours after item 28 is	ETE	4 Homicide determined	building, etc. (Specify				City or Town, State)		
로로	COMPL	(Check only one) 2 MEDICAL EXAMINE	CIAN: To the best of my knowled R: On the basis of examination s			eath occured at the	time, data and place, and d	due to the cause(a)	
TO THE HOSPI TO THE FUNEF be filed within IMPORTANT:	TO BE	296. SIGNATURE AND THE OF CONTRETE		D		DO43	2 83 2	DATE SIGNED	(Month, Day, Year)
		30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEAT	TAL SOL	Hop hun	J Bern	The Contact		
		31. DATE FICEO (Month, Day, Year) NOV 09 1355	Jelin Dhurdeor	URE					

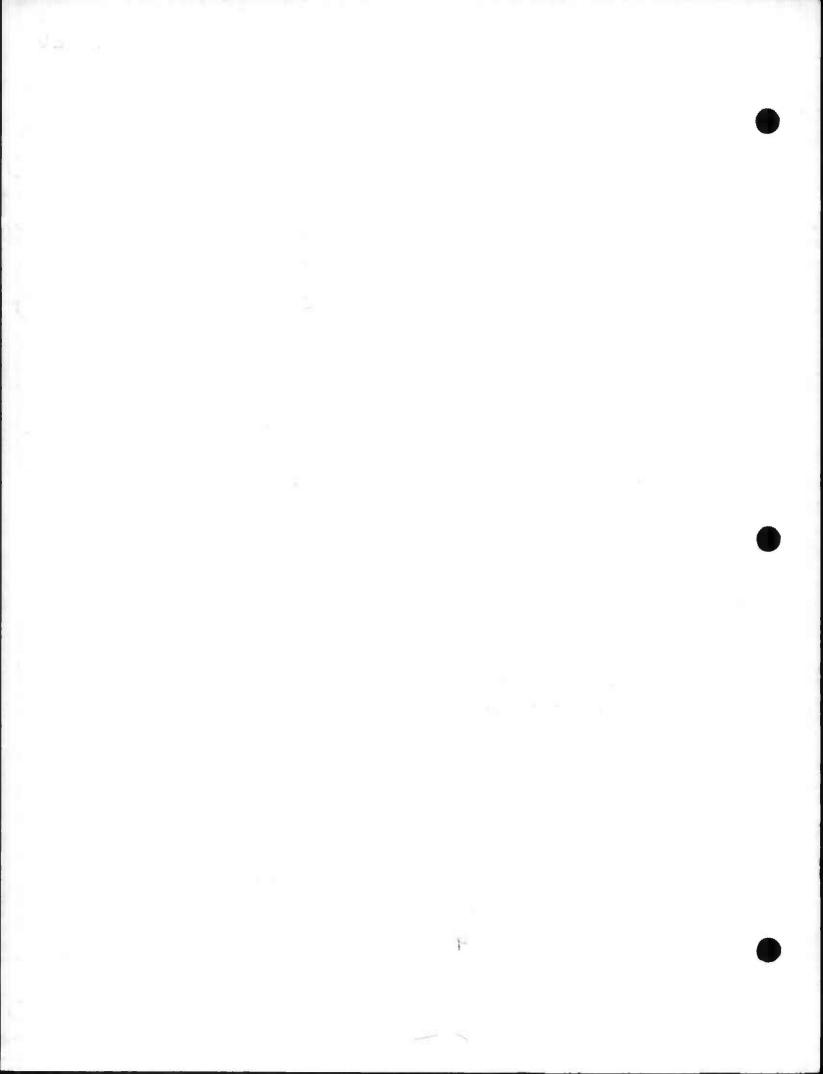
e!

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	COMMERCIAL CONTRACTOR OF THE C
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	1 - STATE OF MARY	LAND / DEPARTMENT CERTIFICATE	OF HEALTH AND	MENTAL HYGIENE REG. NO.							
	1. DECEDENT'S NAME (First, Middle, Last)	OZIIII IOAI Z	OI DEAIN	2. DATE OF DEATH		3. TIME OF DEATN					
	Clara Ball			MONTH DAY	YEAR 95	9:15 A M					
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AC	CIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) if UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTIN 8. BIRTINED.									
	220-36-4711 10 M2 XF	YRS. MONTHS	DAYS HOURS MIN.	1-7-40	N .	Carolina					
1	9a. FACILITY NAME (If not ipstitution, give street and number) Cherywood Heat have	1 com 96. CITY, 1	OWN OR LOCATION OF	DEATN	9c. COUNTY OF DE						
5	12020 Remeterstruk PJ	Reist	erstone mo	21134	BaHimo	we .					
[[RESIDENCE OF DECEDENT 10s. STATE 10b. COUNTY	10c. CITY, TOWN OR				10d. tNSIDE CITY					
DIRECTOR	Maryland N/A Dollings										
	10e. STREET AND NUMBER		10g. CITIZEN OF WI	1 XYES 2 NO							
FUNERAL	6508 Park Heights Avenu	le	21215		US.	A					
١١	11. MARITAL STATUS 12. WAS DECEDENT EVEL FORCES? 1 YE		S DECENDENT OF HISPA	NIC ORIGIN? (Specify Yes o	or No- 14. RACE	- American Indian, White, etc.					
BY F	1 Never Merried 2 Married IF YES, GIVE WAR OF		es, specify Cuben, Mexic ☐ YES 2 ☐ NO Spec		Specify						
ED B	15. OECEDENT'S EOUCATION	Late Decemental visual sea		1		Black					
	(Specify only highest grade completed)	18s. DECEDENT'S USUAL OCC (Give kind of work done du life. Do NOT use retired.)	Ing most of working	16b. KIND OF BUSH							
12	12th College (1-4 or 5+) Nurse Hospital										
COMPLET	17. FATNER'S NAME (First, Middle, Last)		18. MOTHER'S N	AME (First, Middle, Melden Sc	urnsme)						
BE C	James Alston		Carr	ie Park							
TO BE COM	19s. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Route Number, City or Town,	State, Zip Code)						
	Jerelyn Allen	5 Spectat	or Lane,	Owings M:	ills, M	D 21117					
		cometery, crematory or other place)	ON (Name of	DATE 20c. LOCA	ATION — City or Tow	n, Stats					
	4 Donstton 5 Other (Specify)	King Memoria		11/7 Rand	dallsto	wn MD					
1	21. BIGNATURE OF FUNERAL SERVICE LICENSPE		ME AND ADDRESS OF F	ETT & SON	FIMEDA	LUOME					
	LAUNGU () N	1460	O LIBERT	Y HEIGHTS	AVENUE	21207					
	23. PART I mer the diseases, or complications that cause or heart fellure. List only one cause or	the deeth. Do not anter the	e mode of dying, au	ch as cardiac or reapire	itory arrest,	Approximata					
1	IMMEDIATE CAUSE (Final Onset and Daeth										
	disease or condition SEPSIS										
		S A CONSEQUENCE OF):	0								
S	Sequentially list conditions, Right homes to the Preumonia										
AT	Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CALICE CONSEQUENCE OF: LY DER NOTE HIM.										
CERTIFICATION		S A CONSEQUENCE OF):	· 			-					
E	resulting in death) LAST										
	PART II Other significant and distance and the same state of the s										
AL	PART II. Other algorificant conditions contributing to death	- 4	erlying couse given is	Part I. 24s. WAS AN AI PERFORM	IED?	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO					
ă	e de Beovorular a	ecedants		1 YES 2 [COMPLETION OF CAUSE OF OEATH?					
: MEDIC	DID TOBACCO USE CONTRIBUTE TO	CAUSE OF DEATI	YES T N	0 [34		1 TES 2 NO					
A	25. WAS CASE REFERRED TO MEDICAL	CAUSE OF DEATI	t and								
PHYSICIAN: MEDICA	EXAMINER? 1 YES 2 NO 1 Inpetient 2 ER/O	OTHER:	28. PLACE OF DEATH (C								
¥	27. MANNER OF DEATH 28s. DATE OF INJUR	Y 28b. TIME OF 2	g Nome 5 - Residence Bc, INJURY AT	28d. DESCRIBE NOW INJ	JURY OCCURED						
Д У	1 Netural 5 Pending (Month, Day, Yea	r) INJURY M	WORK?								
TED BY PH	2 Accident Investigation 3 Suicide 8 Could not be	IRY — At home, term, street, fector	y, offics	281. LOCATION (Street and	d Number or Rural Ro	ute Number,					
	4 Nomicide determined building, etc. (5	pecity)		City or Town, State)							
片	29e. CERTIFIER (Check only 1 CERTIFYING PNYSICIAN: To the best of my kn	owledge, death occurred at the time	e, data and place, and du	e to the cause(s) and mann	er se stated						
COMPLETED	(Check only one) 2 MEDICAL EXAMINER: On the basis of examine					and manner as stated.					
BE COMPLE	29b. SIGNATURE AND TITLE OF CERTIFIER		29c. LICENSE NU		29d. DATE SIGNED (
	My factoring MM			3867	V1/2/5	5					
유	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF	DEATH (ITEM 27) (Type, Print)			,,,,,,	1					
	M. SATOVNIK, MD										
	31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SI		. 0 .								
	MOV 09	1995 Jahrida	whor Randall								



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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 14 forms after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completally filled in the filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, creminant, or minoral most be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, creminant, or minoral must be notified at once.

													3302	. •
	1 - FOR STATE REGISTRAR	STATE OF N	IARYLAND /	DEPAR	TMEN ICAT	T OF I	IEALTH DEAT	AND I	MEN1	TAL HYGIEN				
	1. DECEDENT'S NAME (First, Middle, Last) TAMES	^	Den	/	1	0				TE OF DEATH		YEAR	3. TIME OF DEA	TH
	4. SOCIAL SECURITY NUMBER	5. SEX	BROW		اله	K.			11	٥.	7	95	7:05	14.00
	231-30-5136	1 🔀 M 2 🗆 F	6. AGE (In yrs. less	YRS.	MONTHS	DAYS	HOURS	24 HRS. MIN.	7. DA (Mc	TE OF BIRTH Onth, Day, Year) 0 - 18-29	9	S. BIRTI Count	HPLACE (State or F	oreign
~	99. FACILITY NAME (If not institution, give s 2912 BRIGHTON						OR LOCATIO	ON OF DE	ATH			JNTY OF D	EATH	
DIRECTOR	RESIDENCE OF DECEDENT	STREET	STREET BALTIMORE N/A						A					
5	10a. STATE 10b. COUNTY	1		10c. CIT	Y, TOWN	OR LOCA	rion						tod. INSIDE CIT	γ
	MD N/A			BA	LTI	MORI	Ξ						LIMITS7	NO
FUNERAL	10e. STREET AND NUMBER					10	. ZIP CODE			-	10g. CIT	IZEN OF Y	WHAT COUNTRY?	
NE I	2912 BRIGHTON						2121					USA		
E.	11. MARITAL STATUS 1 Never Married 2 Married	YES 2 N	MED	13.	WAS DEC	ENDENT OF	F HISPAN	IC ORI	GIN? (Specify Yes	or No-	14. RACI	E — American Ind k, White, atc.	len,	
B	3 Widowed 4 Divorced	IF YES, GIVE W	3-1956					Specify				Spec	"Y: BLAC	K
ED	15. DECEDENT'S EDU	CATION	16a, DE	CEDENT'S	USUAL (OCCUPATION	ON		T	66. KIND OF BUS	SINESS/IN	DUSTRY		
E E	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+) (G/	ve kind of a Do NOT us	vork done ne retired.)	during mo	st of working	9						- 3
COMPLET	12th		LA	BOR	ER					BALTO	. GA	S &	ELECT	. CO
8	17. FATHER'S NAME (First, Middle, Last)						18. MOTH	ER'S NA	ME (Firs	t, Middle, Maiden	Sumame)			
B		ROWN JE						ANCI		TAYLO				
2	19a. INFORMANT'S NAME (Type/Print) NAOMI T. BROW	TNT								imber, City or Tow			01010	
	204, METHOD OF DISPOSITION	114	20b. PLACE A					5T.					21216	
	1 M Buriel 2 Cremation 3 Rem	oval from State	cometery, cres	natory or o	ther place	ODDT	ime or	1 1 1	10	95 OW	CATION -	City or To	rwn, State	
	21. SIGNATURE OF FUNERAL BERVICE LIC	ENSEE	JOAKK	130	22	. NAME A	ND ADDRES	S OF FA	HLITY				LLS, M).
-	16/1/2			_	-	ALE	BERT	P.	WY	LIE E	F/H	PA		
\vdash	23. PART I. Enter the diseases, or	emplications that	caused the de	eth. Do r	ot ente	638	N.	GII	JMO	R STRI	EET	212	217 Approxim	
	shock, or heart failure:	List only one cau	se on each line.		or one		de or dyn	ig, soci	1 44 0	ardiac or reapi	ratory ar	rwat,	Interval B	etween
	iMMEDIATE CAUSE (Final disease or condition	LIVE	RFA	ILUF	LE								Onset an	#TW
	resulting in death)	DUE TO	OR AS A CONSED	UENCE O	F):),,,,,(
Z	Convention like that are distant	RECTAL CANCER 2 YEAR							ARS					
E	Sequentially list conditions, if any, leading to immediate	DUE TO	OR AS A CONSED	UENCE O	7):									
일	CAUSE (Disease or injury	DUE TO	OR AS A CONSED	HENCE D	D.									
CERTIFICATION	that initiated events resulting in death) LAST	502 10 (OH AS A CONSED	VENCE DI	<i>J.</i>								İ	
8		1												
Ä	PART II. Other algnificant condition	s contributing to	deeth but not re	suiting	n the u	nderlying	g cause gi	iven in	Part I.	24s. WAS AN PERFOR		24b.	WERE AUTOPSY F	
MEDICAL									_	1 TYES 2	(A NO		COMPLETION OF OF DEATH?	CAUSE
M													1 - YES 2 -	NO
A	DID TOBACCO USE CONTI	RIBUTE TO CAI			_		UNCE	ERTAIN	1 🗆					
IC.	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: OTHER:													
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO WUNCERTAIN DESCRIPTION OF UNCERTAIN DESCRIPT						her (Specify) ESCRIBE HOW II	N HIRV OC	CLIBED						
						WO	RK7	NO	200. 0	ESCHIBE HOW II	NJUNI OC	CORED		
2 Accident investigation						r or Rural R	Toute Number,							
TED	4 Homicide determined	bunding, (rus (apecity)						C	ty or Town, State)				
COMPLET	29a. CERTIFIER (Check only	CIAN: To the best of a	ny knowledge, des	th occurre	d at the	time, data	and place,	and due	to the c	cause(s) and man	ner as sta	ted.		
OM	0700) 2 MEDICAL EXAMINE) and manner as s	tated.
ш	296. SIGNATURE AND TITUE OF CERTIFIER	AAN		-			29c. LICEN				29d. DAT	E SIGNEO	(Month, Day, Year)	
00	81 1000	MID					D 4	168	39	3		Nove	mber 8th	1995

30. NAME AND ADDRESS DE PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type. Print)

CLARENCE SARKO DEE - HDOO

VIVERS ITY OF MARY AND ANCER

31. DATE FILED (Month, Day, Volar)

NOV 0 91995

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22 S GREENE

CENTER

5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should

notified at

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page		IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be r
Page	al dire		Пег
death.	funer		mex
after	by the	moval	leal e
SUDOL	d in	Or re	med
124	ly fille	ation.	the
with	plete	crem	rent,
cuted	DOO D	urial,	le en
e exe	an an	to b	пша
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ertific	ing p	ygiene	othe
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the d	the	d Mer	Injer
that	led by	th an	any
quires	n Sign	Hea	OWS.
aw re	s bee	pt. o	3 sh
The L	te has	nte De	₽ш 2
IAN:	rtifica	he Sta	Or 15
HYSIC	nis ce	the th	ed,
NG P	fter th	ath y	mark
ENDI	DR: A	ter de	8
R ATT	RECT	urs af	12 E
AL O	AL DI	72 hos	# FE
OSPIT	UNER	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	ANT
포	THE FI	iled w	E
5	2	De f	E

PHYSICIAN:

BY

COMPLETED

BE 2

											9	35	338	22
	1 - FOR STATE REGISTRAR	STATE OF MARY			RTMENT					HYGIEN REG. NO.	E			
	1. OECEDENT'S HAME (First, Middle, Last)						-		2. DATE OF				3. TIME OF OE	ATH
	MARGARET	CALDWELI	Ĺ						Nov			95	11:2	1 pm
			GE (in yrs. lest	t birthday)			IF UNDER		7. DATE OF (Month, D	BIDTH		8. BIRTH	IPLACE (State or	
	210 01 2020	□ M 2 🔀 F	94	YRS.	MONTHS	DAYS	HOURS	MIN.	Sept.	8, 7047	1901	Mar	yland	
~	9a. FACILITY NAME (If not institution, give street in	and number)			9b. CITY	, TOWN C	OR LOCATIO	ON OF DE				NTY OF O		
PO P	Greater Baltimore M	Medical Co	enter			Tows	son_				Ba	ltin	nore	
E	RESIDENCE OF DECEDENT 100. STATE 10b. COUNTY			10c. C/7	TY, TOWN O								10d. INSIDE CIT	
DIRECTOR	Maryland N/A Baltimore							LIMITS?						
₹ 	10e. STREET AHD NUMBER					101	. ZIP CODE	E			10g. CITI	ZEN OF V	WHAT COUHTRY?	
FUNERAL	3907 Walnut Ave.							206				USA		
J.	1 Never Married 2 Married	P. WAS DECEDENT EVE FORCES? 1 YE	ES 2 X H	MED	13. 1	WAS OEC	ENDEHT O	F HISPAN	IC ORIGIN? (S	Specify Yes	or Ho—	14. RACE Black	E — American inc k, White, etc.	dlan,
BY	1 Never Married 2 Married FORCES? 1 YES 2 MHO If yes, specify Cuban, Mexican, Puerto Rican, etc.) Specify: Specify:							"White						
	15. OECEDENT'S EOUCATIO	ЮН	16a, DE(CECENT'S	I IIIIIIII	CCI IDATIC	24		I see to		SINESS/IHD		MITTE	
ETE	15. OECEDENT'S EOUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION (Ghe kind of work done during most of working life. Do NOT use retired.) 15b. KIHO OF							HU UP BUG	INESS/IND	USTHY				
PL	Assembly Line Worker Bendix													
COMPLETED	17. FATHER'S HAME (First, Middle, Last)				7		_		AE (First, Midd					
BE C	Edward Charles Griffin								eth B		-			
TO B	19a. IHFORMANT'S HAME (Type/Print)	. MAILING	ADDRESS	3 (Street a			oute Number,			Code)				
F	Frederick T. Freund	id							timore					
	20a. METHOD OF DISPOSITIOH 1 Burlel 2 X Cremation 3 Removal	from State	20b. PLACE A	ANDDATEC	OF DISPOSI				DATE	_	CATION —		wn, State	
Ì	4 Donation 5 Other (Specify)		Green	MOU	int C	rema	tory	r	11/9	Ba]	timo	re,	MD	
	21. SIGNATURE OF PUNERAL SERVICE LICENSE	EE O					NO ADDRES						1	
	* De Devise	Muss	1						RAL H				07.03.4	
		pilcations that can	sed the der	ath. Do r	not enter	the mo	de of dy	ra K	d., Bi	Or readi	ore,	MD	21214 Approxim	mete
	23. PART I. Enter the diseases, or comp shock, or heart vallure. List IMMEDIATE CAUSE (Final disease or condition									D. 100p.	intory c		Interval	
	resulting in death)	CEREBRO				CID	ENT				<u> </u>		18	hrs
		ATRIAL				TAT								
NO	Sequentially list conditions, b.					N							10	yrs
AT	If any, leading to immediate cause. Enter UNDERLYING	A.S.C.V	. D .	UEHCE OF	F):									
FIG	CAUSE (Disease or Injury that initiated events	DUE TO (OR AS	S A CONSEO	UENCE OF	F):									
E	resulting in death) LAST		- Commonwell Mr. Of J.								ļ			
2														
MEDICAL CERTIFICATION	PART II. Other significant conditions co BRONCHOPNEUMC	ontributing to deeth	but not re	aulting I	in the un	derlying	i cause g	iven in F		PERFOR	MED?	24b.	WERE AUTOPSY AWAILABLE PRIOR COMPLETION OF	OT P
MEC	CONCOCRATIO UPS DE DE TESTOR								OF DEATH?	но				

CONGESTIVE HEART FAILURE DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES INO UNCERTAIN

ΝA

1 YES 2 HO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF OEATH (Check only one) HOSPITAL:
1 M inpetient 2 ER/Outpetient 3 DOA OTHER: 1 YES 2 NO 27. MANNER OF OEATH

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28e. DATE OF INJURY

28c. IHJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED

NA

28b. TIME OF IHJURY 1 WES 2 NAO NA М NA NA 28e. PLACE OF IHJURY — At home, ferm, street, factory, office building, stc. (Specify) 281. LOCATION (Street end Number or Rural Route Number, City or Town, Stete)

29e. CERTIFIER
(Check only

1 CERTIFYING PHYSICIAM: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(e) end manner as stated.

2 MEDICAL EXAMIHER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(e) and manner ea stated.

296. SIGNATURE AND TITLE OF CERTIFIER
SERENT & Nolla MAR

Pending

8 Could not be determined

29c. LICENSE HUMBER D25010

29d. DATE SIGNED (Month, Day, Year)
11/8/95

30. HAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

R. Serena Nolan, M.D. 8035A Harford Rd., Baltimore, Md. 21234

31. DATE FILED (Month, Day, Year) NOV 0 91995

1 Hatural

2 Accident

3 Suicide

4 Homicide

32. REGISTRAR'S SIGNATURE

BALTIMORE, MARYLAND 21215-0020	G PHYSICIAN: The law requires that the death certificate be executed within Z4 hours after death. Page 6 may be retained by the hospital or attending physician.	is certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should the State Dect. of Health and Mental Hydiene prior to burial, cremation, or removal.	
DIVISION OF VITAL RECORDS, P.O. BOX 68760	D THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a	O THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely for the completely for the plantal Hopere prior to burial, cremation	

	1 - FOR STATE REGISTRAR	STATE OF MARYLAN		T OF HEALTH AND E OF DEATH	MENTAL HYGIEN REG. NO	E				
	1. DECEDENT'S NAME (First, Middle, Last)	Canty			2. DATE OF DEATH DO NO		3. TIME OF DEATH			
	4. SOCIAL SECURITY NUMBER		rs. last birthday) # UNDE	R 1 YEAR IF UNDER 24 HRS.	7. DATE OF BIRTH	8. BIR	ITNPLACE (State or Foreign			
	01001	10012 DF 86		DAYS HOURS MIN.	Aug 2,	909	ntn5.C			
TOR	99. FACILITY NAME (If not inatitution, give street PESIDENCE OF DECEDENT	tospita	96. CIT	Ralto	EATN	9c. COUNTY OF	A			
DIRECTOR	100, STATE 10b. COUNTY	JIA	10c. CITY, TOWN	Salto			10d. INSIDE CITY			
	10e. STREET AND NUMBER	0	61	101. ZIP CODE	7	10g. CITIZEN O	F WHAT COUNTRY?			
FUNERAL	11. MARITAL STATUS	2. WAS DECEDENT EVER IN U.	S_ABMED 13	WAS DECENDENT OF NISPA	NIC ORIGIN? (Specify Yes	or No- 14. R/	ACE — American Indian,			
BY	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 YES :		Il yee, specify Cuben, Mexic 1 YES 2 NO Speci	an, Puerlo Rican, etc.) ly:		boothy: Black			
TED	15. DECEDENT'S EDUCA' (Specify only highest grade co	mpleted)	(Give kind of work done life. Do NOT use retired.	during most of working	16b. KIND OF BU	SINESS/INDUSTRY	7			
COMPLET	Elementery/Secondary (0-12)	No P	Longsh	oreman	Steo	emsh	ip Irade			
E COI	Musker Canty Sr. 18. MOTHER'S NAME (First, Middle, Leet) Canty Sr. 18. MOTHER'S NAME (First, Middle, Melden Surname) Jackson									
TO BE COM	190, INFORMANT'S NAME (TyperPrint) Cantu 2848 W. Mulbern St., Balto, 7/2223									
	20a METHOD OF DISPOSITION Suriel 2 Cremetion 3 Remove	al from State 29b.PL	ACE AND DATE OF DISPO	Star Cline	1337 / 1	CATION - City or	Town, State			
	21. Donation 5 Other (Specify)	Aer D	VOSCITI	NAME AND ADDRESS OF F	ICILITY I	atensi	ille, Ira			
	frome-	+. Thomp	an Je	March +.	H-West	Arla				
	23. PART Enter the diseases, or co- ahock, or heart failure. Li-			r the mode of dying, su	ch as cardiac or resp	Iratory arrest,	Approximate interval Between			
ERTIFICATION	IMMEDIATE CAUSE (Final disease or condition	Preumo	nia				Onset and Death			
	resulting in death) a.	DUE TO (OR AS A CO	ONSEQUENCE OF):							
CATION	Sequentially list conditions, if any, leading to immediate	OUE TO (OR AS A CO	Obst (ctive Lu	ing Disc	ease	Les			
FICA	CAUSE (Disease or injury that inhibited events to (OR AS A CONSEQUENCE OF):									
ERTIFIC	that initiated events resulting in deeth) LAST d									
AL CE	PART ii. Other aignificant conditiona				0.0000	N AUTOPSY :	24b, WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO			
1 8	STROKE, De Failure	mention C	ongesti	re Heart	1 TYES	2 NO	COMPLETION OF CAUSE OF DEATN?			
H. ME	DID TOBACCO USE CONTRI	BUTE TO CAUSE OF	DEATH YES	NO UNCERTA	NA		1 YES 2 NO			
SICIAN: ME	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. HOSPITAL:	PLACE OF DEATN (Chec							
×	1 TYES 2 NO	1 Inpatient 2 ER/Outpatie		rising Nome 5 - Residence	6 Other (Specify) 26d, DESCRIBE NOW	INJURY OCCURED				
ВУ РН	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJURY M	WORK? 1 YES 2 NO						
TED	3 Suicide 6 Could not be determined	28e. PLACE OF INJURY — building, etc. (Specify)	ctory, office	281. LOCATION (Street end Number or Rural Route Number, City or Town, State)						
COMPLET	one)	AN: To the bast of my knowled					se(s) and manner se stated			
8	29b, SIGNATURE AND TITLE OF CENTIFIED			29c, LICENSE NI			NED (Month, Day, Year)			
O BE COMPLE	Mh	MD		909		▶ No				
2	30. NAME AND ADDRESS OF PERSON WHO									
	Michael Bo 31. DATE FILED (Month, Day, Year)	nd 301	IIRE	of Place	Ballin	rore w	10 21200			
	NOV 0 91995	the atualism to	while							

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AL OR ATTENDING PHYSICIAN; The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician,	CTOR; After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should after nearth with the Strain Dent, or Health and Mental Moderne prior to burial; cremation, or removal.	is marked
TO THE HOSPITAL OR ATTENDING PHYSICIAN.	TO THE FUNERAL DIRECTOR; After this certific he filed within 72 hours after death with the S.	IMPORTANT: if Item 28 is marked, or i

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEDENT'S NAME (First, Middle, Lest) REBECCA BERTINA CAMPBELL 2. DATE OF DEATH MONTH DAY YEAR 3. TIME OF DEATH									
- -	Bertina R. Campbell Nov 7, 1995 3: 00 F									
	C 100 c 11 1	SEX 6. AGE (In yrs.	VRS. MONT	HS DAYS	HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) MAR 21	923	OTHPLACE (State or Foreign Intry)		
	9a. FACILITY NAME (If not institution, give street and nymber) 9b. CITY, TOWN OR LOCATION OF DEATH 332 Suter Road Catows uille Balto.									
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY									
	Md ba	lto.	Cate	OZUC	.11-6			LIMITS?		
RAL	337 SILLER	ROAN			ZIP CODE		10g. CITIZEN O	F WHAT COUNTRY?		
BY FUNERAL	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO If yes, specify Cuban, Maxican, Puarto Rican, etc.) 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No Black, Whife, afc. 14. RACE — American Indian, Black, Whife, afc.									
	15. DECEDENT'S EDUCATI	ON t8a.	DECEDENT'S USUA	L OCCUPATIO	N	16b. KIND OF BU	SINESS/INDUSTRY	Black		
COMPLETED	(Specify only highest grade com Elementary/Secondary (0-12)	college (1-4 or 5+)	(Give kind of work di life. Do NOT use retin	ed.)	of working	Socio	15eco	reta Admin.		
	17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) ELLA MASON									
TO BE	19a. INFORMANT'S NAME (Type/Print)	ODELL		RESS (Street ar	0	Route Number, City or Tow	n, State, Zip Code)	21228		
	20a. METHOD OF DISPOSITION 1 Burfal 2 Cremation 3 Rarpoval from State 4 Donation 5 Dother (Specify) The Control of the Control									
	21. SIGNATURE OF FUNERAL SERVICE LICENS	11-0		22. NAME AN	h F/H	CILITY	M TUE	FLOX		
-	23. PART I. Enter the diseases, or com	D. Slar	1.00	4300		sh Avenue		O. Md 21215		
	shock, or heart fallura. Lief IMMEDIATE CAUSE (Final disease or condition resulting in dasth) s			tasio	unlum	n priman	3	Intarval Batween Onset and Death		
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated avents	DUE TO (OR AS A COM								
CER	resulting in dasth) LAST									
EDICAL	PART II. Other significant conditions of	ontributing to death but n	ot resulting in the	e undarlying	cause given in	Part I. 24a. WAS AN PERFO	MED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 UPS 2 100		
Z	DID TOBACCO USE CONTRIB	SUTE TO CAUSE OF D	EATH YES	□ NO □	UNCERTAI	NZ				
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) EXAMINER? HOSPITAL: OTHER:									
HAS	1 YES 2 NO t	☐ Inpatiant 2 ☐ ER/Outpatian 28a. DATE OF INJURY	28b. TIME OF	Nursing Home		8 Other (Specify) 28d. DESCRIBE HOW	NJURY OCCURED			
ВУР	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJURY	M 1 1 Y	RK? ES 2 NO					
	3 Suicide 8 Could not be detarmined	28a. PLACE OF INJURY — A building, etc. (Specify)	t home, farm, street,	factory, office		281. LOCATION (Street City or Town, State	and Number or Rui	al Route Number,		
COMPLET	eeel .	N: To the best of my knowledge						e(s) and mannar as stated.		
III.	296. SIGNATURE AND TITLE OF CERTIFIER	1	29c. LICENSE NUI	MBER	29d. DATE SIGN	IED (Month, Day, Year)				
10 BE	gm Oll No D40850 Novemb						nby 8,1995			
	30. NAME AND ADDRESS OF PERSON WHO C				BALT	immes w	10 212	29		
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATUR		7102	4,500	1106 11				

(A)

purial-transit permit. Pages 1, 2, 3 should

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the 1 be filled within 72 hours after death with the State Dept. of Health and Mental Hydiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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BE COMPLETED BY PHYSICIAN: MEDICAL

0

											95	3	382	5
	1 - FOR STATE REGISTRAR	STATE OF MA			TMENT O					GIENE G. NO.				
	1. DECEDENT'S NAME (First, Middle, Last) CHARLES WILLIAM	CHARLES WILLIAM CRANE 2. Date of Death MONTH DAY NOVEMBER 6, 1995												ATH A M
	4. SOCIAL SECURITY NUMBER 234 50 6976	5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRT!										HRTHPL Country)	3:05 LACE (Stone or VIRGIN	
TOR	Fort Howard Veter	90. FACILITY NAME (If not institution, give street and number) Fort Howard Veterans Admn. Hospital 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore 9c. COUNTY OF DE										OF DEA	тн	
FUNERAL DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE Maryland 10b. COUNT		timore								Od. INSIDE CIT LIMITS?			
VERAL	100. STREET AND NUMBER 9600 Northpoint B			101. ZIP 210	52-3	3012				CITIZEN OF WHAT COUNTRY?				
COMPLETED BY FU										RACE - Black, \ Specify:	E - American Indian, ik, White, etc.			
	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) College (1-4 or 5 +) College (1-4 or 5 +) College (1-4 or 5 +) College (1-4 or 5 +) College (1-4 or 5 +)													
BE CO	17. FATHER'S NAME (First, Middle, Last) Bernard Crane 18. MOTHER'S NAME (First, Middle, Maldon Surname) Nannie Holliday													
TO B	190. INFORMANT'S NAME (Type:Print) (W. Je) 190. MAILING ADDRESS (Street and Number or Aural Abute Number, City or Town, State, Zip Gode) Kay Frances Crane 4310 Walnut Road-P.O. Box 864-Buckeye Lak										43008 ke, Oh			
	20e. METHOD OF DISPOSITION 1									or Town	, State			
	21. SIGNATURE OF FORERAL SERVICE LICENSEER ON ald Wade, Dir. State Anatomy Board026-655 W. Bo Baltimore, Maryland 21201-1559											ltimor	e St.	
	23/PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Finel diseases or condition PNEUMONIA, BILATERAL										Approxin Interval I Onset an	Between nd Death		
_	resulting in death)	DUE TO (OF	DUE TO (OR AS A CONSEQUENCE OF): METASTATIC MELANOMA OF UNKNOWN PRIMARY SITE								UNKNO			
CATIO	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING		AS A CONSEOU			THAN	MATA E	VILLIM	T 13T	LE			ONIMIO	MIN
CERTIFICATION	CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OF	AS A CONSEQU	ENCE OF)):									-
9													F	

PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC ALCOHOLISM

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES X NO UNCERTAIN 26. PLACE OF DEATH (Check only one)

25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL:
14 Dispatient 2 - ER/Outpatient 3 - DOA OTHER:
4 | Nursing Home 5 | Rasidence 6 | Other (Specify) 1 TES 2 NO

26e. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 1 Natural
2 Accident

3 Sulcide 6 Could not be determined 4 Homicide

28s. PLACE OF INJURY — At home, farm, atreet, fectory, office building, etc. (Specify) 261. LOCATION (Street end Number or Rural Route Number, City or Town, Stete)

29e. CERTIFIER (Check only 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(e) and menner ee stated. 2 ___ MEDICAL_EXAMINER: On the beels of exemination and/or investigation, in my opinion, death occurred at the time, date and placs, and due to the cause(s) and menner ea stated

28b. TIME OF INJURY

28c. INJURY AT WORK?
1 YES 2 NO

29c. LICENSE NUMBER

29b. SIGNATURE AND TITLE OF CENTIFIER

30, NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print)

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

M.D., 9600 NORTH POINT ROAD, FORT HOWARD, MARYLAND 21052 MARCOS GALICIA, 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE

Jalia Davilson Randall

24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATN?

1 YES 2 NO

29d, DATE SIGNED (Month, Day, Year)

NOV

24a. WAS AN AUTOPSY PERFORMED?

1 - YES 2 NO

26d. DESCRIBE NOW INJURY OCCURED

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			G. CRAI			2.	DATE OF DEATH	3 19	45	TIME OF DEATH	
pir		213 20 1111	XM 2 □ F 64	YRS. MONTHS	DAYS HOURS	s MIN. Ja		1021	BIRTHPLA Country) aryla	ACE (State or Foreign	
, 2. 3 should	CTOR	as FACILITY NAME (If not institution, give street a Good Samaritan RESIDENCE OF DECEMENT	nd number)		nown on Local	ATION OF DEATH	ч	9c. COUNTY	Y OF DEATI	Н	
Pages 1,	i iii i	1 106. STATE 106. COUNTY 106. CITY TOWN OR LOCATION									
<u>a</u> . 2		Maryland		Baltin	more				LIMITS?		
sit permit.	RAL	830 E. Belvedere Ave			101. ZIP CC			10g. CITIZEN OF WHAT COUNTRY?			
020 physician. burial-transit	FUNER	11. MARITAL STATUS 12. 1	WAS DECEDENT EVER IN U.S. AR	RMED 13. V	212		ORIGIN? (Specify Yes		S.A.	American Indian,	
1215-0020 or attending physician. r use as the burial-tra	B	1 Never Married 2 Married 3 Wildowed 4 Divorced	FORCES? 1 √ YES 2 □ N IF YES, GIVE WAR OR DATES US 0 / 51 - 10 / 55	SAF 1	Yes, specify Cu	uban, Maxican, P	Puerto Rican, etc.)		Black, Wi	white	
or atten	ETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUS									
ND 21 hospital or ached for o	PLE	Elementary/Secondary (0-12) Col	Hege (1-4 or 5+)	. Do NOT use reviewo.;							
AND the hospital detached for once.	COMPL	17. FATHER'S NAME (First, Middle, Last)			18, MC	OTNER'S NAME	(First, Middle, Maiden	Sumame)			
# 8 E	l iii	Sherlock Swann Crai			Mil	dred 1	sabel Mon	rris			
MAR retained 5 should notified	2	19a. INFORMANT'S NAME (Type/Print)		b. MAILING ADDRESS							
be age		Louise McElfatrick 200. METNOD OF DISPOSITION		830 E. Bel		. Avenue					
MORE age 6 may director, pa		1 Burial 2 Cremation 3 Removal for 4 Donetion 6 Other (Specify)	cametery, cre	ematory or other place)	TION (Name or	1	DATE 20c. LO	CATION — City	or Town,	State	
Page 1		21. SIGNATURE OF FUNERAL SERVICE LICENSE	Ronald Wade,	Dir. 324	NAME AND ADDI	RESS OF FACILITY	TY IFF	(1) n (0.6	re Street	
BALII Ber death. P. the funeral wal. I examine		Sangue Al	· Clare		B026-B	comy ou	oard-655 re, Maryl	W. Bar	1001	re Street	
n by remo		23. ART I. Enter the diseases, or compleshock, or heart failure. List of	lications that caused the de	eath. Do not enter t	the mode of c	dying, auch as	a cerdiec or reapi	ratory arreal	t,	Approximata	
filled ir on, or		IMMEDIATE CAUSE (Final	mly the cause on each line	J.					j	Interval Between Onset and Death	
		disease or condition reaulting in death)	Cor pulmonale DUE TO (OR AS A CONSEC							3 years	
0 9 7 76	z		Chronic obstru		1monary	· dicas				E	
OX 68 be elecuted in the property of the control o	CATION	if any, leading to immediate	DUE TO (OR AS A CONSEC	OUENCE OF):	Imonary	/ UISEa	se			5 years	
certificate the ding physici hygiene prior other tra	25	cause. Enter UNDERLYING CAUSE (Disease or injury	DUE TO (OR AS A CONSEC	OLIENCE UP							
	RTIE	that initiated events resulting in death) LAST	DOE TO (OIL NO IS OBLIGHED	JUENCE OF J.							
the death the atten Wental H	1 W II	PART II. Other algnificent conditions con	ntelbuting to death but not a		A shake a second	1-0-		100			
1 24 1 1	CAL	rheumatoid arthrit		eeuiting in the unc	Jerlying ceuse	a given in Pari	PERFOR	RMED?	AWA	RE AUTOPSY FINDINGS ILABLE PRIOR TO	
requires that the signed of Health and shows and signed.	MEDIC	interstitial pneum					t TYES 2	™ NO	OF	MPLETION OF CAUSE DEATH?	
Sh of se		DID TOBACCO USE CONTRIBU	TE TO CAUSE OF DEA	TH YES E N	IO UN	ICERTAIN ['-	YES 2 NO	
N: The lan ficate has State Dep	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLAC	CE OF DEATH (Check of	nly one)						
Certification of the St	HYSI	1 YES 2 NO 1	Inpetient 2X ER/Outpetient 3	DOA 4 Nursi	Ing Home 5 🗆	Residence 8 🗆					
Re this PH C	у РНУ	13 Netural 5 Pending	28s. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 YES 2		d. DESCRIBE HOW II	NJURY OCCUR	IED		
NDING NDING Is may	D BY	_	28s. PLACE OF INJURY — At hor building, etc. (Specify)	me, farm, street, fecto			1. LOCATION (Street a	and Number or	Rural Route	Number,	
DR ATTENDING DIRECTOR: After hours after death item 28 Is ma	ETE	4 Homicide detarmined	banany, are toposity				City or Town, State)				
TAL DR A VAL DIREC 72 hours If Item	11		To the best of my knowledge, dea								
HOSPIT FUNER WITHIN	CO	2 MEDICAL EXAMINER; On	the basis of examination and/or is	investigation, in my op	Inlon, death occ	cured at the time), dete and place, en	d due to the co	euse(s) and	f manner as stated.	
TO THE HOSPITAL TO THE FUNERAL OF THE FUNERAL OF THE WITHIN 72 h	BE	296. SIGNATURE AND TITLE OF CENTURES	Ta ii			CENSE NUMBER	3			rith, Day, Year)	
668₹	2	36. NAME AND ADDRESS OF PERSON WHO COM	APLETED CAUSE OF DEATH (ITE	M 27) (Type, Print)	_	035329			1-6-9		
		Dixie Lee Harris,	M.D. Pulmona	ry Departi	ment 3d	1127 10	N. Green	o St.	Ralt	MD 21201	
. [31. DATE FILED (MONTO 9 1995	A RESTROCT HOW HOELD	14				5 50.	Dait.	, IID 21201	
		1101									

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	RAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached

FOR STATE REGISTRAR **CERTIFICATE OF DEATH** REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH YEAR CASTERLINE, SR. BRUCE E. Nov 8 1995 8:00 am M 4. SOCIAL SECURITY NUMBER 7, DATE OF BIRTH (Month, Day, Year 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign t<u>√</u> M 2 ☐ F MONTHS DAYS HOURS 213-01-1977 76 JULY 11,1919 MARYLAND 9e. FACILITY NAME (If not institution, give street and number) 96 CITY TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Saint Joseph Medical Center Towson, Maryland **Baltimore** DIRECTOR RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? 10a. STATE MARYLAND BALTIMORE LANSDOWNE 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 161 HOWARD AVENUE 21227 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 X NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-14. RACE — American Indian, Black, White, etc. 1 Never Merried 2 X Merried If yes, specify Cuben, Mexicen, Puerto Ricen, etc.) IF YES, GIVE WAR OR DATES 1 TYES 2 X NO Specify Specify: BY 3 Widowed 4 Divorced WHITE COMPLETED 15. DECEDENT'S EOUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done during most of working life. Do NOT use retired.) Elementery/Secondary (0-12) College (1-4 or 5+) TILE ESTIMATOR A. PESSARO & COMPANY 11TH GRADE 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surneme) BRUCE CASTERLINE HAZEL (UNKNOWN) notified at BE 19e, INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 BRUCE E. CASTERLINE, JR. 406 HANCE AVENUE - LINTHICUM, MARYLAND 21090 pe 20a, METHOD OF DISPOSITION

1 Burlel 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION -- City or Town, State DATE must MORELAND MEMORIAL PARK 11/11 BALTIMORE 4 Donation \$ D Other (Specify) examiner 21. SIGNATURE OF JUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVENUE-BALTIMORE,
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 4107 WILKENS AVENUE-BALTIMORE, MD 21229 medicai Approximata ahock, or heart fellure. List only one ceuse on each line. Interval Batween **Onest and Death** IMMEDIATE CAUSE (Finel disease or condition the DAYS MYOCARDIAL INFARCTION event, reculting in death) DUE TO (OR AS A CONSEQUENCE OF): CORONARY ARTERY DISEASE YEARS traumatic CERTIFICATION Sequentially list conditions, if any, leading to immediate OUE TO (OR AS A CONSEQUENCE OF): cause. Enter UNDERLYING CAUSE (Disease or injury other DUE TO (OR AS A CONSEQUENCE OF) that initiated events reaulting in deeth) LAST 6 injury. PART II. Other algoriticent conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24a. WAS AN ALTTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? shows any DIABETES MELLITUS 1 YES 2 NO 1 TYES 2 YO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES 🗷 NO 🗌 UNCERTAIN 🗍 PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Hem **EXAMINER?** HOSPITAL:
1 Grapatient 2 ER/Outpatient 3 DOA OTHER: 1 YES 2 DE 4 - Nursing Home 5 - Reeldence 8 - Other (Specify) 0 27. MANNER OF DEATH 28e. OATE OF INJURY 28b. TIME OF INJURY 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED is marked, 1 Netural 2 Accident 5 Pending Investigation M 1 YES 2 NO BY 26e. PLACE OF INJURY — At home, ferm, street, fectory, office building, etc. (Specify) 281. LOCATION (Street end Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be COMPLETED 4 Homicide 200 ltem 29a, CERTIFIER 1 ____RTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end manner ee stated. Ξ TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: II On the besis of examination end/or investigation, in my opinion, death occured at the time, date end place, and due to the cause(e) and menner se stated, CAPDIAC 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 11.8.95 Dould SUPGERY D 26151 2 AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) GARTH MCDONALD, M.D., 7505 OSLER DRIVE, TOWSON, MD. 21204

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

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TO BE COMPLETED BY FUNERAL DIRECTOR

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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for	be filed within 72 hours after death with the State Dept. of Health and Merital Hyglene prior to bunal, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

FOR 1 - STATE REGISTRAR	STATE OF M			MENT OF H	IEALTH AND I	MENTAL		E	J	33020
DECEDENT'S NAME (First, Middle, Last)	Dana	Irene C		CATE OF	DEATH	2. DATE O MONTH	FDEATH 15	199	YEAR S	9:35 P M
4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs.	lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE O	FBIRTH		s. BIRTHPI	LACE (State or Foreign
212-28-1662	1 🗆 M 2 💢 F	79	YRS.	MONTHS DAYS	HOURS MIN.		22.1	916	Virg.	
9a. FACILITY NAME (If not institution, give st	reet and number)			9b. CITY, TOWN	OR LOCATION OF DI				TY OF DE	
Franklin Woods	Nursing	Center		Ross	ville			B	alti	more
RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY			7	TOWN OR LOCA	TION					IOd. INSIDE CITY
Maryland	Baltimo	re				undal	k			LIMITS?
1623 Gray Haven (10	212	22				States
11. MARITAL STATUS 1 Never Married 2 Married 2 Married 3 Widowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No— lif yea, specify Cuben, Mexican, Puerto Rican, etc.) 14. RACE — American In lif yea, specify Cuben, Mexican, Puerto Rican, etc.) 15. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No— lif yea, specify Cuben, Mexican, Puerto Rican, etc.) 16. RACE — American In life yea, specify: Sp									White, etc.	
15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12)	completed)		DECEDENT'S U (Give kind of wo	JSUAL OCCUPATION done during months retired.)	ON ost of working	16b. I	KIND OF BUS	INESS/INDI	JSTRY	
8 Years	College (1-4 or 5	7)	Sale	sperson			Re	tail		
17. FATHER'S NAME (First, Middle, Lest)				-1-2-0011	18. MOTHER'S NA	ME (First, Mi				
William Gay					Rosa	Walke	r			
19a. INFORMANT'S NAME (Type/Print)			19b. MAILING	ADDRESS (Street	and Number or Rural	Route Numbe	c, City or Town	n, State, Zip	Code)	
Ruth Pressley			1623	Gray Ha	ven Ct.	Dund	alk,	Maryl	and	21222
20s. METHOO OF DISPOSITION 1 & Buriel 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of cametery, cemstory or other place) 1 Donation 5 Other (Seech) 20b. PLACE AND DATE OF DISPOSITION (Name of cametery, cemstory or other place) 20c. LOCATION — City or Town, State 20c. Baltimore, Maryland										
22. NAME AND ADDRESS OF FACILITY Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, MD 21222										
23. PART I. Enter the disesses, or chock, or heart fellure. IMMEDIATE CAUSE (Final disesse or condition	omplications the List only one cer	st odused the use on each li	desth. Do no ne.	ot enter the mo	ode of dying, suc	ch es cardi	sc or respi	ratory srr	est,	Approximate Interval Between Onset and Death
resulting in desth)	P DUE TO	OR AS A CONS	SEQUENCE OF):						two days
Sequentially list conditions, if any, leading to immediate ceuse. Enter UNDERLYING	DUE TO	(OR AS A CONS	SEQUENCE OF):						
CAUSE (Disease or Injury that initiated eventa resulting in death) LAST	DUE TO	(OR AS A CONS	SEQUENCE OF):						
DAST II. Other elgolflood condition		death but as				1			1.	
Chronic Obs	tructire				ISEASE	Part I.	24a. WAS AN PERFOR	IMED?	+	WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH?
DID TOBACCO USE CONTI	RIBUTE TO CA	USE OF DE	ATH YE	S I NO I	UNCERTAI	пП				YES 2 AIG
25. WAS CASE REFERRED TO MEDICAL				H (Check only one						
EXAMINER?	HOSPITAL:	ER/Outpatient	3 DOA	OTHER	ne 5 🗆 Residence	8 Other	(Speciful			
27. MANNER OF DEATH	28a. DATE O	FINJURY	28b. TIME	OF 28c. IN	JURY AT	_	RIBE HOW I	NJURY OCC	URED	
1 Natural 5 Pending	(Month, I	Day, Year)	INJU		YES 2 NO					
3 Suicide 8 Could not be determined	3 Suicide 8 Could not be 28. PLACE OF INJURY — At home, farm, streel, factory, office building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29e. CERTIFIER 1 CHERTIFYING PHYSI (Check only one) 2 MEDICAL EXAMINE										and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIED	hardso	-mD	>		29c. LICENSE NU					Month, Day, Year) ber 6, 1995
30. NAME AND ADDRESS OF PERSON WH CANOL RICHARD					SQUARE	E DAY	16,	Balt	-ingo	re MD 237

CAROL RICHARDSON MD 9000 FRANKLIN SQUARE DRIVE

31. DATE OF GOOD FOR SOUTH SQUARE DRIVE

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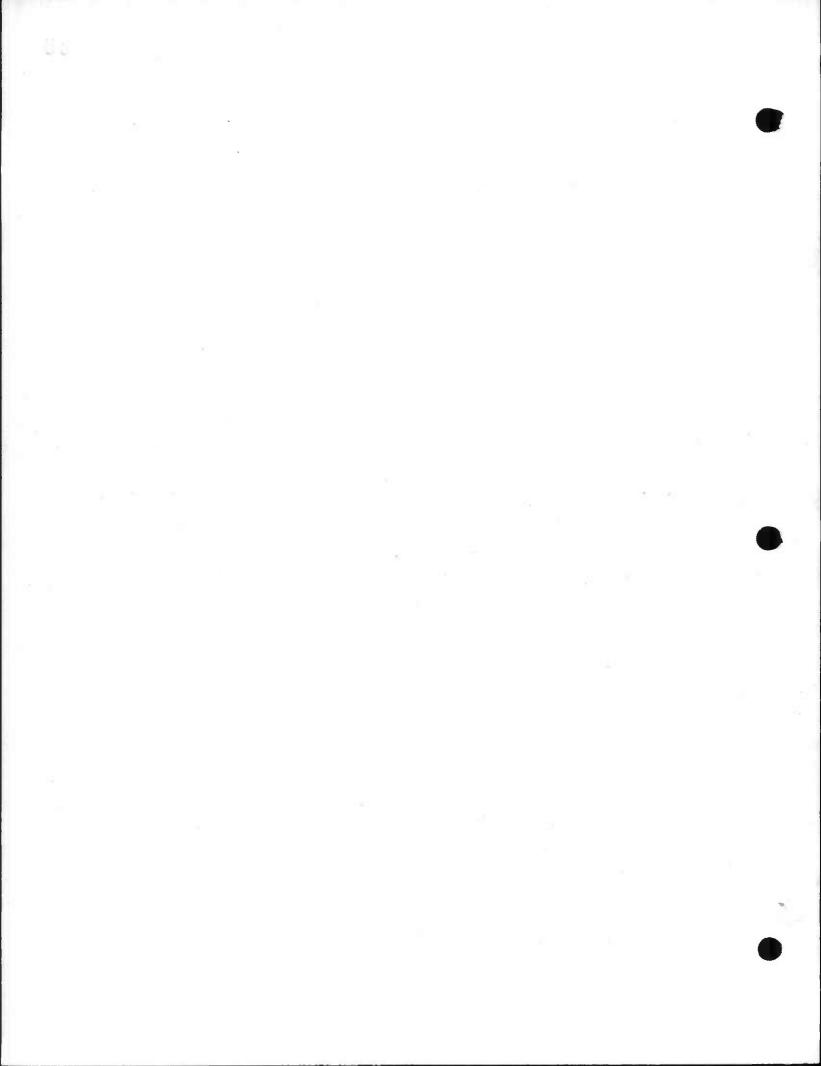
HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	FUNERAL DIRECTOR: After this centificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	enteresting to to with the contract of the contract of the second to second one metallical and contract of the second to the
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	FOR STATE REGISTRAR	STATE OF MARYL		ENT OF HEALTH ANI	MENTAL	HYGIENE REG. NO.						
	t. DECEDENT'S NAME (First, Middle, Last)	LABETH	DUNC	AN	2. DATE OF MONTH	T 31 19	3. TIME OF DEATH					
	4 SOCIAL SECURITY NUMBER	5. SEX 6. AGE	UNDER 1 YEAR IF UNDER 24 HR	3. 7. DATE OF	7. DATE OF BIRTH B. BIRTNPLAGE (State or Foreign							
	90, EACILITY NAME (If not institution, give street end number) 90, EACILITY NAME (If not institution, give street end number) 91. CITY, TOWN OR LOCATION OF DEATH 91. CITY, TOWN OR LOCATION OF DEATH											
5	Deaton Nursing Home Balto NA											
DIRECTOR	top STATE 10b. COUNT	NIA	10c. CITY, TO	WHOR LOCATION			10d. INSIDE CITY LIMITS? 1 YES 2 NO					
	10e. STREET AND NUMBER 10g. CITIZEN OF WI											
FUNERAL	3915 COU away the 213 21215 U. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. APMED 13. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Yee or No- 14. RACE.											
BY FI	t Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 YES	2 X NO	If yes, specify Quben, Me. 1 YES 2 NO Sp	xican, Puerto Ric ecily:	can, etc.)	specify: Black					
ED	ts. DECEDENT'S EDU (Specify only highest grade		16a, DECEDENT'S USU (Give kind of work life, Do NOT use re	done during most of working	16b. K	CIND OF BUSINESS/INDUS	TRY					
COMPLE	Elementary/Secondary (0-12)	College (1-4 or 5+) NA		Jorked	1	JA	2-1-1					
~	17. FATHER'S NAME (First, Middle, Last)	noore		18, MOTHER'S	NAME (First, Mic	ddle, Meiden Sumamel	arber					
O BE	190. INFORMANT'S NAME (Type/Print)	1166	19b. MAILING AD	DRESS (Street and Number or Ru	1	City or Town, Spans, Zip Co	ide) 1 md					
	200, METNOD OF DISPOSITION 20											
	Donation 5 Other (Specify)	A 1	Tac M Sch		FACILITY .	owing	is mills, md					
	1/3me	H. 1/	mosm	March,	F.H-	west	3/3					
		List only one cause on a	ach line.				Interval Between					
	disease of cyndition resulting in death) . NON-HODGKINS LYMPHOMA STAGE IV 3 YEARS											
_	DUE TO (OR AS A CONSEQUENCE OF):											
ALIO	Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING											
CERTIFICATION	CAUSE (Disease or Injury that initiated svents resulting in death) LAST	DUE TO (OR AS	A CONSEQUENCE OF):									
	PART II, Other significant condition	d	but not resulting in t	ne underlylng cause glyer	in Part I	24a. WAS AN AUTOPSY	24b, WERE AUTOPSY FINDINGS					
SICAL	PANCYTOPE			na underlying causa giver		PERFORMED?	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATN?					
: MEDIC	DID TOBACCO USE CONT	RIBUTE TO CAUSE (DE DEATH YES	□ NO TAL UNCERT	AIN 🗆	`	1 YES 2 NO					
SICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEATH		7		<u></u>					
È	t U YES 2 NO 27. MANNER OF DEATH	1 Inpetient 2 ER/Out 28e. DATE OF INJURY	patient 3 DOA 4	Nursing Nome 5 Resider		(Specify)	RED					
ВУР	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	Y — At home, lerm, stre	M 1 YES 2 NO		TION (Street and Number or	Devel Devile Newther					
TED	3 Suicide a Could not be 4 Homicide determined	building, etc. (Spe	ecffy)	n, ractory, office		Town, State)	Autai Hode Hunibel,					
COMPLET	one)			t the time, date end piece, end			suse(a) and manner ea stated.					
296. SIGNATURE AND TITLE OF CERTIFIER 296. LICENSE NUMBER 296. LICENSE NUMBER 296. D31136 D31136 DCT 31, 1995												
									2	30. NAME AND ADDRESS OF PERSON WI	NO COMPLETED CAUSE OF D	EATN (ITEM 27) (Type, Pri
TO		NO COMPLETED CAUSE OF D		S. CHARLE	3 5%	BACTIMO	26, mg 21230					

grave a figure of the second o

4 hours after death. Page 6 may be retained by the hospital or attending physician,	his certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should with the State Dent, of Health and Mental Hydiene prior to burial, cremation, or removal.	
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the be filed within 72 hours after death with the State Deat; of Health and Mental Hydiene prior to burial, creampal,	

		FilmG, 7: FOR 1. STATE	29, ite	em #1.9a, STATE OF I	11/ MARYL	AND /	DEPAR	TMENT	OF H	EALTH		MENT	AL HYGIEN	E DU		
Г		REGISTRAR 1. DECEDENT'S NAME (First,	Addedda Lood			CE	RIIF	ICATE	OF	DEA	TH		REG. NO.			
		TA .) /	V C	5	4.1	KI	0					MOI	TE OF DEATH	W A 7	YEAR	3. TIME OF DEATH
		4. SOCIAL SECURITY NUMB	5. SEX	6. AGE	In yrs. les	t hirthday)	IF UNDER 1	/EAR	IE IMPE	R 24 HRS.		VEMBER TE OF BIRTH	07	1995	PLACE (State or Foreign	
		577-40-3		56	YRS.	MONTHS	DAYS	HOURS	MIN.				Country	NC .		
	œ	9e. FACILITY NAME (If not institution, give street and number) CHURCH HOME HOSPITAL BALTIMORE										EATH			NTY OF D	EATH
	DIRECTOR	RESIDENCE OF DEC		105P1TA				BA	۲,I, T	HUM	(E			N/C		
	Ä	10a. STATE	10b. COUNTY				10c. CIT	Y, TOWN OR	LOCAT	ION						10d. INSIDE CITY
	5	MD.	N/A				BA	LTIM	ORE	E					_	LIMITS7
	ERAL	10s. STREET AND NUMBER								ZIP COD				10g. CITI	ZEN OF W	HAT COUNTRY?
	E	1734 N. E	BOND S	STREET					2	2121	. 3				US	A
	FUN	11. MARITAL STATUS		12. WAS DECEDEN	T EVER IN	U.S_AR	MED	13. W	S DECE	ENDENT	OF HISPAN	IIC ORIG	GIN? (Specify Yes	or No-		— American Indian,
	8	1 Never Married 2 3 Wildowed 4 Divo		IF YES, GIVE							Specify		lo Hican, atc.)		Specif	
		21	EDENT'S EDUC													BLACK
	ELE	(Specify only	highest grade	completed)		(Gi		VOIK done du			ing	1	66. KIND OF BUS	INESS/IND	USTRY	
		Elementary/Secondary (0 12th	-12)	College (1-4 or 5	+)			RY W	a go	GT3			UNK			
once.	COMPL	17. FATHER'S NAME (First, Mi	iddle, Last)			1. 1	1010	1(1 11			HER'S NA	ME (Flos	t, Middle, Maiden	Sumamel		
16	EC	THOMAS YO	DUNG								IZAB					
notified	8	19a. INFORMANT'S NAME (7)				196	. MAJLINO	ADDRESS (Street ar	nd Numbe	r or Rurel I	Poute Nu	imber, City or Town	n, Stata, Zip		
100	은	MARY -	AULK	BALLA	ARD		1734	N.	BOI	ND S	ST.	BAI	LTIMOR	E, M	D.	21213
st be		20a. METHOD OF DISPOSITI	ON 3 Person	noi from State				OF DISPOSIT					ATE 20c. LO	CATION —	City or To	wn, State
r must		4 Donation 5 Other (Specify) BEATTIES FORD CEM. 11-11-95 CHAROLETTE, N.C.														
nine	1	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY ALBERT P. WYLIE F/H PA														
examiner	ALBERT P. WYLIE F/H PA 638 N. GILMOR STREET 21217												17			
or other traumatic event, the medical	RTIFICATION	23. PART I. Enter the di shock, or he immediate CAUSE (Fin disease or condition resulting in death) Sequentially list condition from the cause. Enter UNDERLY! CAUSE (Disease or injuntat initiated events resulting in death) LAST	ona, diate	DUE TO	GLA OR AS A (OR AS A	CONSECUTION CONSECUTION		eart of						ratory arm	eat,	Approximate Interval Between Onset and Death 2.5 who.
	G	PART II Other elcolitics	at conditions		4 45 1		-						1			1
shows any injury,	MEDICAL	PART II. Other algnifice	hall	Failu	ceeth b	ut not re	euiting	m the unde	nying	ceuse	given in	Part I.	24a. WAS AN PERFOR		24b.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO
78 ar		Diagram	1	leitur									1 YES 2	NO NO		OF DEATH?
shov		DID TOBACCO US		-	LISE	E DEAT	TU VE	C D N		11516	SEDTA IN					1 YES 2 NO
1 23	PHYSICIAN:	25. WAS CASE REFERRED TO		IBUIE IO CA				H (Check on		UNC	CERTAIN	у Ц				
Item	SIC	EXAMINER?		HOSPITAL:				OTHER:								
D, 04	Ě	27. MANNER OF DEATH		28a. DATE OF	INJURY	WITHOUT 3	28b. TIM		c. INJU	IRY AT	seldence		ESCRIBE HOW IN	JURY OCC	URED	
marked,	ВУР		Pending nvestigation	(Month, E	lay, Ybar)		INJ	URY M	WOF	NK? ES 2] NO		CHECKS ENGINEE			9.7
in in	80	2 0 0-1-14:	Could not be	28a. PLACE C	F INJURY atc. (Spec	— At hor	ne, ferm, s	traet, tectory	office	Person		28t. LC	OCATION (Street a	nd Number	or Rural A	oute Number,
28	쁘	4 Homicide	letermined	Domaing,	are lobec	<i>""</i>						Cit	ty or Town, State)			
후	PLE	29a, CERTIFIER 1 CERTI	IFYING PHYSIC	IAN: To the best of	my knowl	edge, des	ith occurre	d at the time	, data a	and place	, and dua	to the c	euse(a) and man	ner na atate	ed.	
Ë	COM															and manner as stated.
MIA	S I	396 SIGNATURE AND TITLE	OF CERTIFIER							29c. LIC	ENSE NUN	18ER		29d. DATE	SIGNED	(Month, Day, Year)
2	00	peterario	Tu/	med	Spe	-cia	list			2	403	356	,	N 10	11/20	1800 00 100
	٩	30. NAME AND ADDRESS OF	PERSON WHO	COMPLETED CAU			27) (Type,	Print)	al	ot in	a p		MD.	212	23/	, ,,,,,,
		31. DATE FILED (Month, Day,)	rbar)	32. REGISTRA			0	1		7 100		_ /	(I/)	J . , Z	7/	
	1	NOV	0 919	32. REGISTRA	de	deer	Karla	M								



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, Page 6 may be retained by the hospital or attending physician. THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	be filed within 72 hours after death with the State Dept, or Health and Merital Hypere prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.	
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	FOR 1 - STATE REGISTRAR	STATE OF MARYLAND /		T OF HEALTH AND E OF DEATH	MENTAL HYGIENE		
	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH		3. TIME OF DEATH
	PEARL F	ROSE GELLER	R		NOVEMBER 5	,1995	1:00 A M
	4. SOCIAL SECURITY NUMBER 5.	SEX 8. AGE (in yrs. las		R 1 YEAR # UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTH	PLACE (State or Foreign
	212-70-1810 1 9a. FACILITY NAME (If not institution, give street	M 2 X F 85	YRS. MONTHS	DAYE HOURS MIN. Y, TOWN OR LOCATION OF E	OCT. 9, 1	910 NEW	YORK
DIRECTOR	5 PRIMROSE STREET			CHEVY CHA	SE		GOMERY
E	10a. STATE 10b. COUNTY		10c. CITY, TOWN	OR LOCATION	. == 1		10d. INSIDE CITY LIMITS?
ā	MARYLAND N/A	A	1	BALTIMORE			t V YES 2 □ NO
AL	10e. STREET AND NUMBER			101. ZIP CODE		10g. CITIZEN OF W	WHAT COUNTRY?
E	6711 PARK HEIGHTS A	AVE., APT. 301		21215		USA	
BY FUNERAL	11. MARITAL STATUS 1	. WAS DECEDENT EVER IN U.S. AR FORCES? 1 TYES 2 TH IF YES, GIVE WAR OR DATES	RMED 13.	WAS DECENDENT OF HISPA If yes, specify Cuban, Maxic t YES 2 NO Speci	en, Puerto Ricen, atc.)		- American Indian, k, White, atc. hy: WHITE
8	15. DECEDENT'S EDUCATION	ON 16a. DE	ECEDENT'S USUAL (OCCUPATION	16b. KIND OF BUS	INESS/INDUSTRY	WILLE
	(Specify only highest grade com Elementary/Secondary (0-12) C	ollege (1-4 or 5 +)	live kind of work done b. Do NOT use retired.	during most of working			
뒫		4	F	OUSEWIFE		OWN_HOM	E
COMPLETED	17, FATHER'S NAME (First, Middle, Last)			18. MOTHER'S N	AME (First, Middle, Maiden S	iurneme)	133
BE (UNKNOWN			BLUM	Δ	U	NKNOWN
2	19a, INFORMANT'S NAME (Type/Print) ALAN			S (Street and Number or Rura			
-				SE STREET CH	EVY CHASE,	WD 20812	
	20a METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Removal	from Stata cemetery, cre	AND DATE OF DISPO)	DATE 20c. LOC	CATION — City or To	wn, State
	4 Donation 5 Other (Specify)	BAI	TTMORE F	EREW 1	1-7-1995 -	REISTERS	TOWN, MD
	P 10	16	0 - 12	OL LEVINSON	& BROS., I	NC.	
	allersu	- our		O10 REISTER			E, MD 21215
	23. PART I. Enter the diseasea, or com shock, or heart failure. List	plications that caused the de Dnly Dne cause on each line		r the mode of dying, su	ch as cardiac or respir	atory arreat,	Approximate Interval Between
	IMMEDIATE CAUSE (Final disease or condition resulting in death)	Acute N	Wocan	led Infa	iction		Onset and Death
		DUE TO ON AS A CONSE	QUENCE OF):	Ca Dec	vas des	. 1	
N	Sequentially list conditions,	Atleus	allin	c Carpu	vas des	earl	
A E	If any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A CONSE	OUENCE OF):				
5	CAUSE (Disease or Injury C.	DUE TO (OR AS A CONSE	OUENCE OF)				
CERTIFICATION	that initiated events resulting in death) LAST						
빙	0						1
AL:	PART II. Other significant conditions of	ontributing to death but not r	1-		Part I. 14a. WAS AN A PERFORM		WERE AUTOPSY FINDINGS AMALABLE PRIOR TO
2	HYPETCHOUS	y, aoug	NY	My of D.	1 YES 2	NO NO	OF DEATH?
F	- Pankyon	of atrial t	/eucosx	Jan 1/00	Mey		1 TYES 2 THO
ä	DID TOBACCO USE CONTRIB			NO UNCERTA	IN ID		
PHYSICIAN: MEDIC		OSPITAL:	CE OF DEATH (Check		9 11F 1910 F 2 8 1 11 1 - 2 8 2 9		
IYS	1 TYPE 2 MAG 11	Impatient 2 ER/Outpatient 3	_	rsing Home 3 Mesidence	_		
	1 Matural 5 Pending	(Month, Cey, Well)	38% TIME OF INJURY	29c, MUURY AT WORK?	284. DESCRIBE HOW BY	JUNY OCCURED	
B∀	2 Accident Investigation	28s. PLACE OF INJURY At he	note term street for	1 VES 2 NO	38f. LOCATION (Sheef as	or Number of Greek	Sinte Milater
ED	3 Suicide 6 Could not be 4 Homicide determined	building, etc. (Specify)		norg, arrice	City or freen, State)	to member or regard	nos norses.
COMPLET	29a. CERTIFIER						
MP	one)	N: To the best of my knowledge, de On the basis of examination and/or					a) and manner as eleted
8	296. SIGNATURE AND TITLE OF CERTIFIER	0 0 1	moonganon, m my				
BE	One mil	1100 100		200. LICENSE M	7888	▶ 1// P/	5/07
2	36. NAME AND ADDRESS OF PERSON WHO O	DMPLETED CAUSE OF DEATH SITE	M 27) (Type: Print)	02	0 44	11/08	2/15
	Allen M Fried	nan.711 1/140	Street	#400	Batto 1	10	2/2//
	31. BALLIAN DING LOCK	The selector Carolalle	7.00		1000 /1	100	/
	1010 0 1335						

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

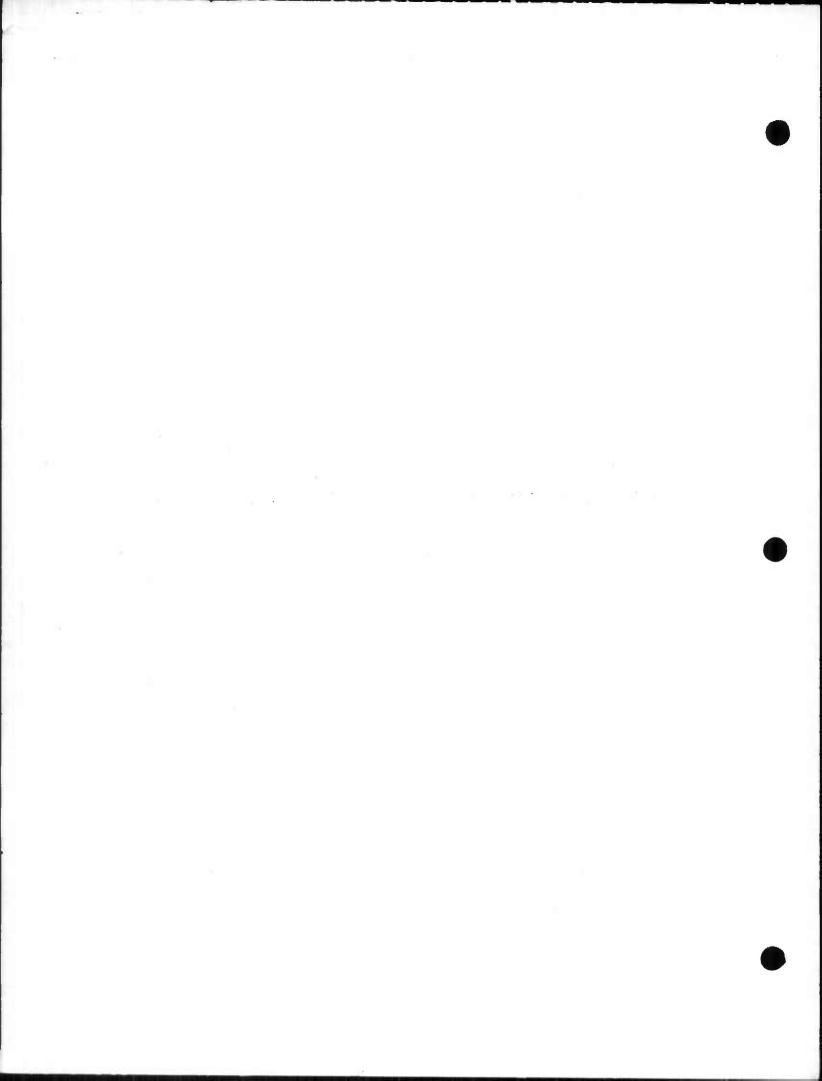
IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

	FOR
1	STATE
	REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

•	1. DECEDENT'S NAME (First,				GRE	בוומים				2. DATE OF D	27,	100	95 ^{SAR}	3. TIME OF DEATH 6:00 P. M
	ELIZABETH		- anu					1		OCT.		19:		
	4. SOCIAL SECURITY NUME	SER	5. SEX 1 M 2 XF	8. AGE (In yrs. In 73	est birthday) YRS.	MONTHS	DAYS	HOURS	R 24 HRS. MIN.	7. DATE OF B	7, 1	922	Count	IPLACE (State or Foreign Y)
	9a. FACILITY NAME (If not in	stitution, give s	treet and number)			9b. CIT	Y, TOWN	OR LOCAT	ION OF DE	EATH	I	9c. COU	NTY OF D	EATH
DIRECTOR	1202 W. E	AYETT	TE ST.			BAI	LTI	MORE						
E C	10e. STATE	10b. COUNTY	,		10c. CIT	Y, TOWN	OR LOCA	TION						10d. INSIDE CITY
	Maryland				Ва	ltim								1 X YES 2 NO
Z	100. STREET AND NUMBER		04 4				19	of. ZIP COD				10g. CIT	IZEN OF	WHAT COUNTRY?
١	1202 W. Fag	jette.							202					
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 3 Widowed 4 Divo			IT EVER IN U.S. A YES 2 MAR OR DATES		13.	If yes, s		en, Mexica	NIC ORIGIN? (S _i in, Puerto Ricen y:		or No—	14. RACI Blac Spec	E — American Indian, k, White stc. thy: Black
ED	15. DEC	EDENT'S EDU	CATION	16a. D	DECEDENT'S	USUAL	OCCUPAT	ION		16b. KIN	D OF BUS	INESS/INC	DUSTRY	
LETE	(Specify onli Elementary/Secondary (I	y highest grade 3-12)	completed) College (1-4 or 5		(Give kind of life. Do NOT u	work done se retired.)	during m	ost of work	ing					
COMPLET	17. FATHER'S NAME (First, A	fiddle, Last)						18. MOT	THER'S NA	ME (First, Middle	e, Maiden S	Sumame)		
BE C														
2	19a, INFORMANT'S NAME (Type/Print)			19b, MAILING	ADDRES	SS (Street	and Numbe	or or Rural	Route Number, C	ity or Town	, State, Zip	Code)	
	20e. METHOD OF DISPOSIT 1	on 3 🗆 Rem			E AND DATE crematory or o			ieme of	- 4	OATE	20c. LOC	CATION —	City or To	own, Stata
1	21. SIGHAPORE OF FUNKER			ld Wado	Din	22	. NAME /	AND ADDRI	ESS OF FA	CILITY				
	Sanual	111	1 bee	<u> </u>	, , ,	3	tate m.Bl	2 Ana 126-8	tomy	Board more. 1	-655 Maruk	W. 1 land	3alt	imore Street 201-1559
-	23. JART I. Enter the d													Approximate
	IMMEDIATE CAUSE (Fi		List only one ca					N				0		Onaat and Daath
	disease or condition	→		Athen	o.scl	1 sh	,	Car	lin	asaile	2/	Hus	2000	
	resulting in death)	,		OR AS A CONS										
z			b.											
CERTIFICATION	Sequentially list condi- if any, leading to imme	diate	DUE TO	(OR AS A CONS	SEOUENCE (OF):								
2	cause. Enter UNDERLY CAUSE (Disease or inju		c											
E	that initiated events resulting in death) LAS	T.	DUE TO	OR AS A CONS	SEQUENCE C	λF):								
5月			d							-				
	PART II. Other aignifica	ent condition	ns contributing to	daath but no	t reaulting	in the u	ınderiyi	ng cauae	given in	Part i. 24	. WAS AN		240	. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
MEDICAL										1(YES 2			COMPLETION DF CAUSE OF DEATH?
													- 1	1 YES 2 NO
	DID TOBACCO U	JSE CONT	RIBUTE TO CA	AUSE OF DE	ATH Y	ES 🗆	NO [JUN	CERTAI	NO				
A	25. WAS CASE REFERRED				ACE OF DE									
Sic	EXAMINER? 1 X YES 2 □ NO		HOSPITAL:	☐ ER/Outpatient	3 DOA	OTHE		me 5X	Residence	8 Other (Sc	necify)			
PHYSICIAN:	27. MANNER OF DEATH		28e. DATE O		28b. TI			JURY AT		28d. DESCRI	BE HOW IP	NJURY OC	CURED	
		Pending Investigation	(Workin,	Day, Year)	***	JURY		YES 2	□ NO					
ВУ	2 Accident 3 Suicide g	Could not be		OF INJURY - At	home, farm,	atroot, fa	ctory, off	lca				nd Numbe	or or Rural	Floute Number,
COMPLETED	4 Homicide	determined	bunung	, atc. (Specify)						City of R	own, State)			
2	29a. CERTIFIER (Check only	TIFYING PHYS	ICIAN: To the best of	of my knowledge,	death occur	red at the	time, de	te and plac	ce, and du	a to the cause(a	i) and man	ner as sta	rted.	
M		DICAL EXAMINI	ER: On the beals of	examination and/	or investiget	lon, In my	opinion,	death occ	ured at the	e time, data and	place, and	d due to t	the cause	(s) and manner as stated.
	29b. SIONATURE AND TITL	E OF CERTIFIE	R /					29c. LI	CENSE NU	MBER		29d. DA	TE SIONE	D (Month, Day, Year)
BE	Non	111	A Ch	inte				0.	.C.M	LE.				28, 1995
임	30. NAME AND ADDRESS O		COMPLETED CA											
		HUTE				Penn	St	ree	t, E	Baltim	ore	, Ma	ryl	and 21201
	31. DATE FILEO (Month, Day NOV 0	9 1905	Jahr de	AR'S BIGNATION	really									



ermit. Pages 1, 2, 3 should

APO THE	五年 五	RTAN	SPITS NERA NT: 1	AL DIS	R ATT RECTT UITS af	DR: A	After leath	this c with	CIAN: ertific the Si	The ate he tate D	aw re is bee ept. o ept. o	quires n sign f Healt	that shed by tth and	the de the d	ath contraction that Hy	ng ph giene giene other	ysiciar prior trau	execution and purity particular and purity purity and p	complication in complete compl	etely 1 ematio nt, th	filled ir n, or e me	by the remova	other traumatic event, the medical examiner must be notified at once.
HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Z4 hours after FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or remova ATANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Z4 hours after TO THE FUNERAL DIRECTOR. 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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 -CERTIFICATE OF DEATH REG. NO. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATN BOBBY EARI GOODWIN NOVEMBER 1995 2350 P 7. DATE OF BIRTH
JUL. 25, 15011)1956 B. BIRTHPLACE (State or Foreign Country) S. C AROLINA A SOCIAL SECURITY NUMBER 5 SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 215-82-5488 1 X 2 F 39 MONTHS DAYS HOURS MIN. VRS Sa. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 1200 BLOCK ENSOR STREET DIRECTOR n/a BALTIMORE CITY 10a. STATE IDC. CITY, TOWN OR LOCATION 10d. INSIDE CITY

V LIMITS?

YES 2 NO 10b. COUNTY MARYLAND n/a BALTIMORE FUNERAL 10e STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 710 PARK AVENUE apt. 21201 UNITED STATES 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 V. VYES 2 NO IF YES, GIVE WAR OR DATES 8/30//6- 8-28/81 11. MARITAL STATUS 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yas or No-14. RACE — American Indian, Black, White, stc. 1 Never Married 2 Married If yes, specify Cuban, Maxican, Puerlo Rican, etc.) 1 TYES 2X NO BY Specify Specify: BLACK 3 Widowed 4XX Divorced COMPLETED 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5 +) 12 FRESH DOUGH DISTRIBUTORS th TRUCK DRIVER 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) JOHN GOODWIN DOROTHY BROWN BE 19s. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 BRENDA 710 PARK AVENUE, BALTIMORE, MARYLAND 21201 GOODWIN 9 20c. LOCATION — City or Town, State
NEWPORT, N. CAROLINA 20a METHOD OF DISPOSITION 1 Duriel 2 Cremetion 3 20b. PLACE AND DATE OF DISPOSITION (Name of Ship DATE TEMPORT Other PlaCEMETERY 11-11 4 Donation 5 Other / Time SIGNAPLINE OF FUNERAL BI 22. NAME AND ADDRESS OF FACILITY WM. C. MARCH FH.-1101 E. NORTH **AVENUE** Enter the diseases, or complications that caused the dasth. Do not enter the mode of dying, such as cardiac or respiratory street, shock, or haart failure. List only one pause on each line. PART I. Enter the disess Approximate Interval Between Onset and Death IMMEDIATE CAUSE (Final MULTIPLE GUNSHOT WOUNDS e disease or condition resulting in death) event, DUE TO (OR AS A CONSEQUENCE OF) traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Diseasa or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated evants resulting in death) LAST PHYSICIAN: MEDICAL PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY WERE AUTOPSY FINDINGS PERFORMED? AVAILABLE PRIOR TO any COMPLETION OF CAUSE 1 YES 2 | NO OF DEATH? SHOWS TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\Boxed{1}\) NO \(\Boxed{1}\) UNCERTAIN \(\Boxed{1}\) 2 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Tem EXAMINER? OTHER:
4 | Nursing Home 5 | Residence 1 | Inpetiant 2 | ER/Outpetiant 3 | DOA 8 (XOther (Specify) AT SCENE ò 27. MANNER OF DEATH 28a, DATE OF INJURY 284 DESCRIBE HOW INJURY OCCURED 28b. TIME OF 28c. INJURY AT WORK? marked, 1 Netural 1 YES 2 NO SHOT SOVERAL TIMES BY 2 Accident 281, LOCATION (Street and Number or Rural Route Number, 3 Suicide 28 18 COMPLETED 6 Could not be 1200 BLK ENSOR ST. BALTIMORE 4 Homicide STELET item 29s. CERTIFIER 1 CERTIFYING PNYSICIAN: To the beat of my knowledge, death occurred at the time, = 2 X MEDICAL EXAMINER: On the basis of ex SIGNATURE AND TITLE OF CERTIF 29c. LICENSE NUMBER 29d, DATE SIGNED (Month, Day, Year) 图 NOVEMBER 8,1995 O.C.M.E. 2 AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) - My

DHMH-16 Rev 1/89

111 Penn Street, Baltimore, Maryland 21201

FOR STATE REGISTRAR

4. SOCIAL SECURITY NUMBER

580-01-7421

Maryland

(Specify only hi

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Harry

IMMEDIATE CAUSE (Final diseese or condition

CAUSE (Disease or Injury

that initiated events resulting in death) LAST

resulting in deeth)

11. MARITAL STATUS

1 -

DIRECTOR

FUNERAL

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2

CERTIFICATION

MEDICAL

PHYSICIAN:

ВУ

COMPLETED

BE

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HYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	thinks certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should with the State Dent. of Health and Mental Motiene prior to burial, cremation, or removal.	rked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the 1 he find within 72 hours after death with the State Deor of Health and Mental Hydiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other tr

95 33834 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 2. DATE OF DEATH DAY 1. DECEDENT'S NAME (First, Middle, Last) 3. TIME OF DEATN YEAR Helen Dorothy Goeggel 1995 November 8, 8:00pm 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIFTN (Month, Day, Year) 8. BIRTNPLACE (State or Foreign IF UNDER 1 YEAR IF UNDER 24 HRS. 1 M 2 1 Sept. 7, 87 1908 New York 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF GEATN 9c. COUNTY OF DEATN 1928 Stillwater Road Eldersburg Carroll County 10b. COUNTY toc. CITY, TOWN OR LOCATION 10d, INSIDE CITY t TYES 2 X NO Carroll County Eldersburg 10g, CITIZEN OF WHAT COUNTRY? 10f. ZIP CODE 1928 Stillwater Road 21784 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Maxican, Puarto Rican, etc.) 14. RACE — American Indian, Black, White, atc. FORCES? 1 YES 2 NO 1 Never Married 2 Married t TYES 2 X NO Specify 3 Widowed 4 Divorced White 18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. OECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) Businesswoman General Business 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname) Joseph McCarthy Helen Mulligan 19a, INFORMANT'S NAME (Type/Print) 19b. MAILING ADORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Christie Lamping 1928 Stillwater Road Eldersburg, MD 21784 20s. METHOD OF DISPOSITION
1 □ Burlal 2 【Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) 20c. LOCATION - City or Town, State 20b. PLACE AND DATE OF DISPOSITION /Name of DATE Carroll Cremation Serv. 11/9/95 Hampstead, MD 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY HAIGHT FUNERAL HOME (P.O. Box 195) Sykesville, MD 21784 (410)-795-1400 23. PART I. Enter the biseases, or complications that saused the death. Do not enter the mode of dying, such as cardisc or respiratory strest, shock, by heart failure. List only one cause on each line. Approximats interval Between Onset and Death 6 Yrs. ARDIOMYOPATITY
DUE TO (OR AS A CONSEQUENCE OF): CORDINARY Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING DUE TO (OR AS A CONSEQUENCE OF): 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO OBSTRUCTIVE PULMONARY COMPLETION OF CAUSE 1 TYES 2 NO

PART II. Other algorificant conditions contributing to deeth but not resulting in the underlying causa given in Part I.

1 YES 2 NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 🗵

25. WAS CASE REFERRED TO MEDICAL		CE OF DEATH (Check	conty one)	
1 YES 2 NO	HOSPITAL: 1 Inpatient 2 ER/Outpatient 3	OTHE	R: Insing Nome 5 KResidence	6 Other (Specify)
27. MANNER OF DEATN 1 Natural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	26b. TIME OF INJURY M	28c. INJURY AT WORK? 1 YES 2 NO	26d. DESCRIBE HOW INJURY OCCURED
3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJURY — At he building, atc. (Specify)	ome, term, streat, fa-	ctory, office	281. LOCATION (Street and Number or Rural Route Number, City or Town, State)

t CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data end place, and due to the cause(s) and menner as stated.

one) 2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion	n, death occured at the time, data and place, at	nd due to the cause(e) end manner es stated.
296. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)

022342

30.	NAME	AND	ADDRESS	OF	PERSON	WHO	COMPLETED	CAUSE	OF	DEATH	(ITEM 27)	(Туре,	Print)

MICHAILL N. RUBINSTEIN,	M.O.,	300 E.	33RO	ST. #501,	BALTO.	Md.	2/2/8

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DIVISION	

	1. DECEDENT'S NAME (First, Middle, I	Lesti	CERTIFI	CATE OF DEA		REG. NO.	_	3. TIME OF OEATH
		Myrtle Emm			Nov	member	4, 1995	12:25 PM
	4. SOCIAL SECURITY NUMBER 212-22-9753	1 □ M 2 💢 F 9	(In yrs. last birthday) YRS.	IF UNDER 1 YEAR IF UNDER MONTHS DAYS HOURS	Jav	te OF BIRTH onth, Day, Ybar) 1. 22, 1	Cou	MNPLACE (State or Foreign intry) St Virginia
OR	90. FACILITY NAME (If not institution, Meridian Loch	Raven Nursing	Ctr.	Baynesvi			9c. COUNTY OF Balt	imore Co.
DIRECTOR	RESIDENCE OF DECEDEN 100. STATE Maryland		10c. CITY	r, TOWN OR LOCATION	osedale			10d. INSIDE CITY LIMITS?
	100. STREET AND NUMBER 1813 Ellinwoo			101. ZIP COD		7		1 VES 2 NO
BY FUNERAL	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 YES IF YES, GIVE WAR OR	2 X (NO	13. WAS DECENDENT If yes, specify Cube 1 YES 2 NO	en, Mexican, Puert		or No — 14. RA Bit	d States CE — American Indian, ack, White, etc. acity: tyle i to
ED	15. DECEDENT'S (Specify only highest	grade completed)	16e. DECEDENT'S (Give kind of w	USUAL OCCUPATION vork done during most of worki e retired.)	ing 1	6b. KIND OF BUS	INESS/INOUSTRY	White
COMPLET	8 Years 17. FATHER'S NAME (First, Middle, Las	College (1-4 or 5 +)	House		NER'S NAME (Firs		n Home	
BE	Pleasant Viers 198. INFORMANT'S NAME (Type/Print)		19b. MAILING		erva Co	chran		
5	Wilma J. Webbe	ア	1813	3 Ellinwood	Road R	osedale		
	*XXBuriel 2 Cremetion 3 4 Donation 8 Other (Specify)	Removal from State		igth Cem. 11	/7/1995	Ва	ltimore	, MD
	· Chal	h/ X	2///	Duda-Ruck				
	23. PART T. Enter the discesses ahock, or heart fall IMMEDIATE CAUSE (Final disease or condition	lura. Liat only ona cause on	each line.		ring, auch aa c	ardiac or respir	ratory arreat,	Approximate Interval Between
ERTIFICATION	IMMEDIATE CAUSE (Final	a. Oue TO (OR AS DUE TO (OR AS C.	each line.	enter the mode of dy	ring, auch aa c	ardiac or respir	ratory arreat,	Approximate Interval Between
REDICAL CERTIFICATION	ahock, or heart fall IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant cond	a. OUE TO (OR AS DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS	A CONSEQUENCE OF A CONSEQUENCE OF A CONSEQUENCE OF	enter the mode of dy enter the mode of dy enter the mode of dy enter the mode of dy	alven in Part I.	Duscas	AUTOPSY MED? 2	Approximate Interval Betwoonset and De Samuel Samue
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TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 5.5 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR CERTIFICATE OF DEATH REG. NO.											
3	1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH											
	James Richard Hubbard NOV 3 95 1030 pm											
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthdey) F UNDER 1 YEAR F UNDER 24 HRS. 7. DATE OF BIRTH (Morth, Day, Year) 121 4 4 4 4 4 4 4 4 4											
R	Be FACILITY NAME (If not institution, give street and number) Beater Medica Center Salto On Town or Location of Death On Town											
210	RESIDENCE OF DECEDENT											
DIRECTOR	10a. STATE 10b. COUNTY, 10c. CITY, TOWN OR LOCATION, 10d. INSIDE CITY LIMITS? 1 Ves 2 \(\sqrt{N} \) NO											
FUNERAL	10a. STREET AND NUMBER 3720 FLOWER AND Rd 21229 10g. CITIZEN OF WHAT COUNT											
S	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No											
ВУ	1 Never Married 2 Married 2 Married 3 Married 4 Divorced FDRCES? 1 YES 2 ND If YES 2 ND If YES 2 NO Specify: Black, White, etc. Specify: Black, White, etc. Specify: Black, White, etc.											
밀	15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working											
COMPLETED	Elementary (0-12) Salles (14 or 5+) Helpo NOT use relied) Roofing Company											
BE CON	Educad Lee Aubbard 18. MOTHER'S NAME (First, Middle Maiden_Surname)											
TO B	196. INFORMANT'S NAME (Type/Print) Richardson 3720 Flower ton Rd Balto, and 21229											
	20e_METHOD OF DISPOSITION DATE 20e_Location City or Town, Sieta											
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY											
	Yola March Hart f H- west Ave											
	23. PART i. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, abock, or heart fallure. List only one cause on each line.											
	IMMEDIATE CAUSE (Final disease or condition resulting in death) a. CHRONIC OBSTRUCTIVE DUMONARY DS VAS											
_	DUE TO (DR AS A CONSEDUENCE OF):											
CERTIFICATION	Sequentially list conditions, If any, leading to immediate DUE TO (OR AS A CONSEDUENCE OF):											
S	cause. Enter UNDERLYING CAUSE (Disease or injury											
E	that initiated events DUE TO (DR AS A CONSEQUENCE DF):											
E	resulting in death) LAST											
	PART il. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY FINDINGS											
EDICAL	PERFORMED? MAILABLE PRINCE TO											
	1 YES 2 NO COMPLETION OF CAUSE OF DEATH?											
Σ	1 YES 2 ND											
PHYSICIAN:	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 28. PLACE OF DEATH (Check only one)											
S	EXAMINER? HOSPITAL: OTHER:											
¥	NAMES OF GENTLE											
	1 Natural 5 Pending (Month, Day, Year) INJURY WORK?											
B	2 Accident (1998) Accident (19											
COMPLETED	Suicide 6 Could not be determined determined 281. Cocal Dr. (Specify) 281. Cocal Dr. (Street and Number or Rural Route Number, City or Town, State)											
3	296. CERTIFIER 1 1 CERTIFYING PHYSICIAN; To the hard of an installation of the hard of the har											
₹	(Check only one) CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.											
8												
BE	296. SIGNATURE AND TITLE OF CERTIFIER 296. LICENSE NUMBER 296. LICENSE NUMBER 296. A SIGNED (Month, Day, Year)											
2	30. MAME AND ADDRESS OF PERSON WHD COMPLETED CAUSE OF DEATH (ITEM 27) (Typa, Print)											
	BRIAN C. WACLACE, MD 611 S. CHARLES ST. BASTO MD 21230											
	NOV 0 9 1995											

0.5 BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO BE COMPLETED BY FUNERAL DIRECTOR

1 - STATE REGISTRAR		STATE OF MA		/ DEPARTI			MENTA	AL HYGI				
1. DECEDENT'S NAME (First,	Middle, Lest)	George L	ео На	hn				E OF DEATH	1		3. TIME OF DEATH	1
GEORGE	E LEC	HATHA	ĵ				MON	TH &	DAY	YEAR 5	2:00	PM
4. SOCIAL SECURITY NUMBER			_	last birthday)	F UNDER 1 YEAR	IF UNDER 24 HRS.		E OF BIRTH		8. BIRTH	IPLACE (State or For	nign .
217 65 28 90. FACILITY NAME (# not ins		1 M 2 - F	76	YRS.	ONTHS DAYS	HOURS MIN.	61	1th, Day, You	10	Counti	FICKOLL	-
74 LIBERT		,		1.5		OR LOCATION OF D			9c. COU			
RESIDENCE OF DEC		*			MEN	MINST			C 16	HZ	OLL	
10e. STATE	10b. COUNTY			10c. CITY,	TOWN OR LOCAT	TION					10d. INSIDE CITY	
Mp.	CAR	CROLL		WE	2577411	NSTER					LIMITS?	10
10e. STREET AND NUMBER		, , , , ,				. ZIP CODE		-	10g. CITE	ZEN OF V	WHAT COUNTRY?	
74 LIBE	ERTY	ST				2115	7			2,5	A .	
11. MARITAL STATUS		2. WAS DECEDENT E	VER IN U.S.	ARMED	13. WAS DEC	ENDENT OF HISPA		IN? (Specify			- American India:	
1 Never Married 2 1		FORCES? 1 [NO	If yes, sp	ecify Cuben, Mexic	en, Puerto	Ricen, etc.		Bleci	c, White, etc.	
3 Widowed 4 Divor	bes		011 0A120		1 123	Joseph Speci	ıy.			Speci	"CVH LTE	
	EDENT'S EDUCAT		16e.	DECEDENT'S US	SUAL OCCUPATION	ON	16	b. KIND OF	BUSINESS/IND	USTRY		
Elementary/Secondery (0-		College (1-4 or 5+)	\dashv	life. Do NOT use r	k done during mo retired.)	st of working						
				Upholst	erer			Uphol	stery			
17. FATHER'S NAME (First, Mic	ddle, Last)					18. MOTNER'S NA						
George Fran	klin					Helen	Buck	ingha	ım			
190. INFORMANT'S NAME (Ty	pe/Print)			19b. MAILING AL	DDRESS (Street o	nd Number or Rural				Code)	21157	
Elaine M. E.	sworthy	1		327 Old	1 New W.	indsor R	oad-	westn	inster	. Mo	ruland	
20e. METNOD OF DISPOSITIO	ON			E AND DATE OF			DA	7	LOCATION -			
1 Duriel 2 Cremetion 4 X Donetion 6 Other		al from State	cemetery,	crematory or other	r place)					J. C. Harris		
21. SIGNATURE OF FUNERAL	SERVICE LICEN	isee konald	Wade	, Vir.	22 NAME A	D ADDRESS OF F	MGILITY .	1 155	(1) D	0+:	nore Stre	n #
1	111	I hen.										ee
miller	////	mee				26-Balti		-	-		71-1559	
23. ART I. Enter the dis	seasea, or con ert fallura. Lis	mplications that ca st only Dna cause	sused the	death. Do not	entar the mo	da of dying, au	ch aa car	rdiac or ra	apiratory arr	eat,	Approximation Interval Bet	
IMMEDIATE CAUSE (Fine	al										Onset and	
disease or condition resulting in death)	+ .	ARRH	YTH	MIA							MINE	
Toolking in double,		DUE TO (OR	AS A CONS	SEQUENCE OF):								*
	D.	SEIZE	PRE	Dise	EDE	7					YRS	_
Sequentially list condition If any, leading to immed	ons,			SEOUENCE OF):								
Cause, Enter UNDERLYIN CAUSE (Disease or injur												
that initiated events		DUE TO (OR	AS A CONS	SEQUENCE OF):								
resulting in death) LAST	d.											
PART II. Other eignifican	at conditions	contributing to de	ath but no	t resulting in	the underlying	a neuron misson in	Don't I					
	T GOTTGITTONG (John Dating to de	otti bat no	t resulting in	the underlying	g cause given in	Plift I.		AN AUTOPSY FORMED?	240.	WERE AUTOPSY FIN AVAILABLE PRIOR TO	0
								1 TYES	2 XNO		OF DEATN?	USE
									•		1 - YES 2 - N	0
DID TOBACCO US		3UTE TO CAUS	E OF DE	ATH YES		UNCERTAI	N Z					
25. WAS CASE REFERRED TO EXAMINER?		OSPITAL:	26. PL	ACE OF DEATH								
1 YES 2 NO		☐ Inpatient 2 ☐ EF	VOutpatient		THER: Nursing Hom	5 KResidence	6 🗆 Oth	er (Specify)				
27. MANNER OF DEATN		28e. DATE OF INJ (Month, Day, 1)	URY (har)	28b. TIME C	OF 28c. INJ	URY AT	26d. DE	SCRIBE NO	W INJURY OCC	URED		
	Pending nvestigation	,,,,	,	,,,,,,,,,		rES 2 NO						
a C autota	Could not be	28e. PLACE OF IN building, etc.	JURY At	home, farm, stre	et, fectory, offic	•	28f. LO	CATION (Stre	et and Number	or Rural F	loute Number,	
	letermined	bunding, etc.	(chronik)				(Jin)	or Town, St	w(8)			
29e. CERTIFIER 1 CERTI	FYING PHYSICIA	AN: To the best of my	knowledge	death occurred	et the time date	and plane and div	to the co			.4		
		On the beele of exami									and money	
		- Journal of Grant	mid/	Jangarioni,	, opinion, o			- win blace				req.
29b. SIGNATURE AND TITLE		Thele,	> A4	7		29c. LICENSE NU	MBER		29d. DATE	SIGNED	(Month, Day, Year)	
Theep				_		D 369	20		1 - 1	1/4	1/0/2	
30. NAME AND ADDRESS OF	LI PS	DME, A	OF DEATH (I			EZSTO	R Com	20	REIS	TEIC	course	M
31. DATE FILED (Month, Day, Y		13/lucustrian's						-				2
I NOV 0.9	1339	Juan, auto	metalic a	mount								

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1. 2. 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

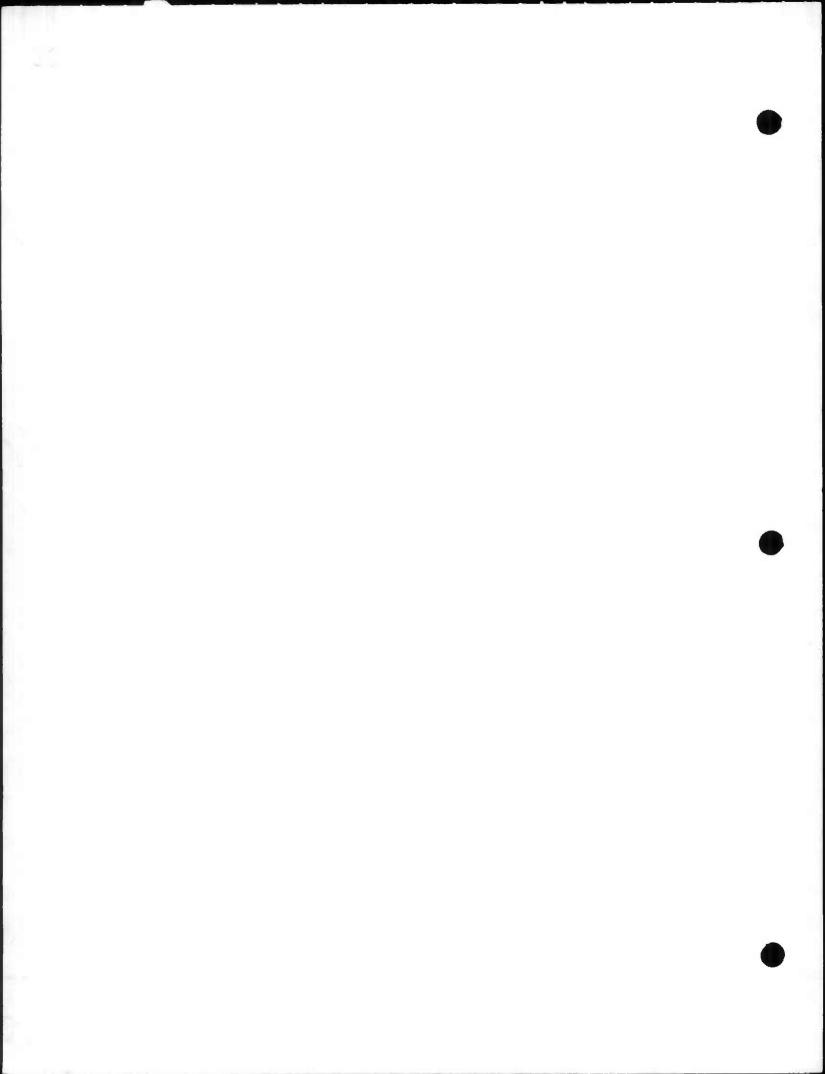
IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 - STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

_	HEGISTRAN	CENTIF	ICALE OF	DEATH	REG. N	0.					
	1. DECEMENT'S NAME (First, Michille, Last) Esther M. Ha		k.a.		2. DATE OF DEATH		3. TIME OF DEATH				
	220-16-42/2 10M2 8F 1	In yrs. last birthday) YRS.	F UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	MIN. 3-28-18 North (
E E	Da. FACILITY NAME (II not institution, give street and number) Anne Arundel Medical Center	9ь. city, тош Annax	OR LOCATION OF D	EATH	9c. COUNTY OF DEATH						
CTC	RESIDENCE OF DECEDENT					Anne Arundel					
DIRECTOR	10a. STATE 10b. COUNTY Maryland Anne Arundel		Y, TOWN OR LOCA	TION			10d. INSIDE CITY LIMITS?				
	100. STREET AND NUMBER	napolis	or. ZIP CODE	10a CITIZEN	0F WHAT COUNTRY?						
FUNERAL	701 Glenwood Street-Apt. 405		21401		и	.S.A.					
ВУ	11. MARITAL STATUS 1 Never Married 2 Married 3 X Wildowed 4 Divorced 12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2 K NO	If yes, s	CENDENT OF HISPA pecify Cuben, Mexico 8 2 X NO Specif	NIC ORIGIN? (Specify 1 an, Puerto Rican, etc.) y:		RACE — American Indian, Black, White, etc. Specify:Black				
	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	16a. DECEDENT'S	USUAL OCCUPATI	ON not of working	16b. KIND OF B	USINESS/INDUST	RY				
COMPLETED	Elementary/Secondary (0-12) College (1-4 or 5+)	Housewi	vork done during m le retired.)	ost or working							
Š.	17. FATHER'S NAME (First, Middle, Last)			18. MOTHER'S NA	ME (First, Middle, Maide	n Sumeme)					
BE (James Brayboy				Morrison						
6	196. INFORMANT'S NAME (Type/Print) Vaster 9. Brédgewater	19b. MAILING	ADDRESS (Street	and Number or Rural	Route Number, City or To	wn, State, Zip Cod	(0)				
							D.C. 20011				
	1 Dariel 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify)										
	21. SIGNATURE OF BERAL SERVICE LICENSEE Ronald Wa	ide, Dir	State	Anatomy	our Board-655 Jore, Mary	W. Bal	timore Street				
	23. PART I. Enter the diseases, or complications that caused ahock, or heart fellure. List only one cause on ea	the death. Do n	ot enter the mo	oda of dying, suc	h as cerdiac or res	piratory arrest,	Approximata				
	IMMEDIATE CAUSE (Final disease or condition resulting in death)		KR 53	57			Interval Between Onset and Daath				
NO.	Sequentially list conditions, If any, leeding to immediate	CONSEQUENCE OF	EMA	FAW	RUF						
CAT	If any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury										
CERTIFICATION	that initiated events resulting in death) LAST	CONSEQUENCE OF	7:								
CER	d										
	PART II. Other significent conditions contributing to death bu	it not resulting i	n the underlyin	g cause given in		N AUTOPSY PRMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO				
EDICAL	Medousm				1 🗆 YES		COMPLETION OF CAUSE OF DEATH?				
Σ	DID TOBACCO USE CONTRIBUTE TO CAUSE OF	DEATH VE	C [] NO [1 LINICEDTAIN			1 - YES 2 - NO				
AN	25. WAS CASE REFERRED TO MEDICAL 2	6. PLACE OF DEAT		UNCERIAII	<u>и</u> П						
PHYSICIAN:	EXAMINER? 1 YES HOSPITAL: 1 Inpetient 2 ER/Outpet	tient 3 🗆 DOA	OTHER:	ne 5 🗆 Residence	6 Other (Specify)						
BY PH	27. MANNER OF DEATH 1	26b, TIMI INJI	URY WO	HURY AT DRK? YES 2 NO	28d. DESCRIBE HOW	INJURY OCCURE	D				
	3 Suicide 6 Could not be 4 Homicide determined	At home, ferm, s	treet, factory, offic	0	281. LOCATION (Street City or Town, State	and Number or Ru	ral Route Number,				
PL	29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge)										
COMPLET	one) 2 MEDICAL EXAMINER: On the basis of axaminetion	and/or investigation	n, in my opinion, d	leath occured at the	time, date and place, a	and due to the cau	see(a) and manner as stated.				
#	29b, SIGNAT, TO TITLE OF CERTIFIER			29c. LICENSE NUM	ABER (C)	29d. DATE SIG	NED (Month, Day, Year)				
2	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEAT	TH (ITEM 27) (Type,		1 4 5	4	0	//3				
	31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNAL	WIS -	Junear	1 pro	MANY	2005	10412				
	NOV 09 1995 Jeli davelor	and the		6							



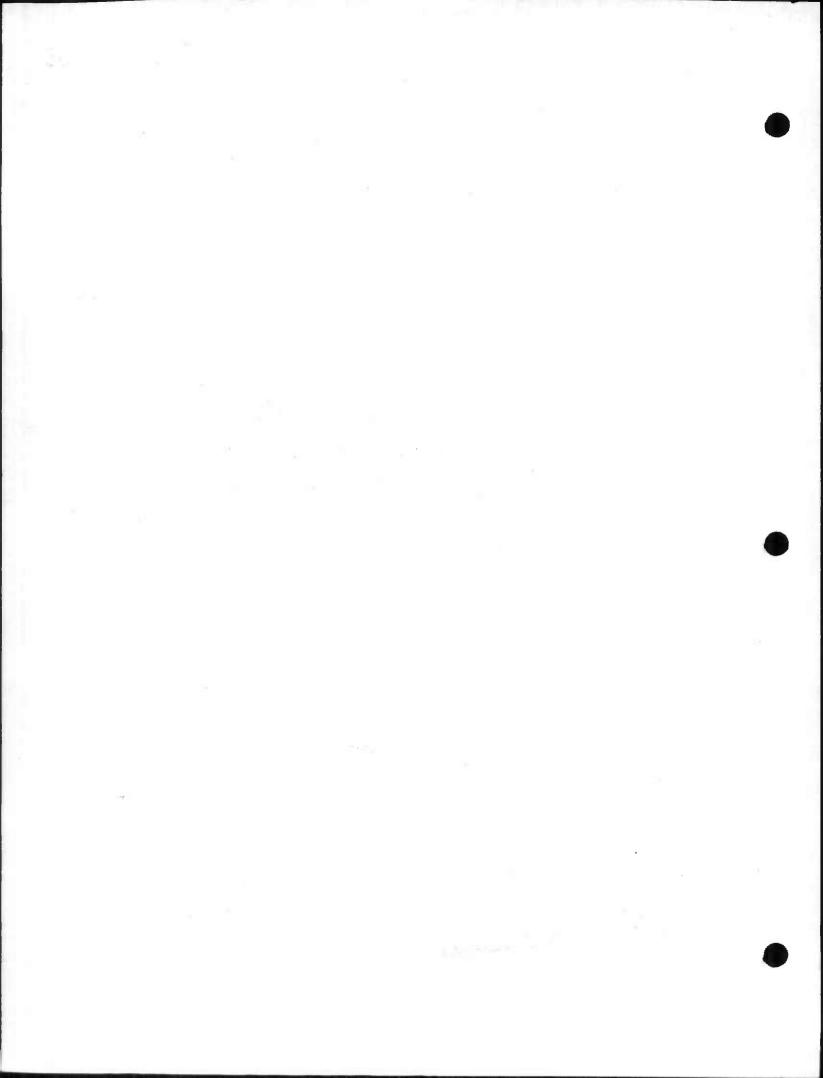
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Memial Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR	C	ERTIF	ICATE (F DEATH		REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE O	OF OEATH		1 2 2 -	3. TIME OF DEATH
	MEMORY			намрт	ON	MONTH	DA		YEAR	5 04 p M
	4. SOCIAL SECURITY NUMBER 5. SEX	6. AGE (In yrs. Ia	et hirthday)	IF UNDER t YE	AR IF UNDER 24 HRS.	7. DATE O	MRER		995	7 • 24 P M
	242-12-1949 1 🗆 🗓 🖺 🖂 🗸 🗆 F	79	YRS.	MONTHS DA			6,1915	5	Nountry	"CAROLINA
	9a. FACILITY NAME (If not institution, give street and number)			9b. CITY, TO	WN OR LOCATION OF D	EATN		9c. COUN		EATH
DIRECTOR	UNION MEMORIAL HOSPIT	AL		BALT	IMORE CI	TY			n/a	
2	10a, STATE 10b, COUNTY		10c. CIT	Y, TOWN OR L	CATION					10d. INSIDE CITY
루	MARYLAND n/a			BALT						LIMITS?
	,			DAL I.						XX YES 2 NO
₹ I	100. STREET AND NUMBER				101. ZIP CODE					HAT COUNTRY?
FUNERAL	2207 HOMEWOOD AVENUE				21218			UNI	TED	STATES
5	11. MARITAL STATUS 12. WAS DECEDEN				DECENDENT OF HISPA			or No-	14. RACE	- American Indian, White, atc.
BY F	1 Never Merried 2 Merried IF YES, GIVE W	YES 2 X	MO.		YES XIX NO Specific		ican, etc.)		Speci	70/000
	15. OECEDENT'S EDUCATION	16a. D	ECEDENT'S	USUAL OCCU	PATION	18h	KIND OF BUS	INESS/INDI	ISTRY	
E I	(Specify only highest grade completed)		Give kind of v	work done durin	g most of working	1000		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
٦	Elementary/Secondary (0-12) College (1-4 or 5 -	•)	PRES	SER			CLE	EANER:	S	
COMPLETED	17. FATNER'S NAME (First, Middle, Last)		111120	JEIN	ta. MOTHER'S NA	AME (Eins A)	ieletta Admielan	Cuma ma)		
	WILLIAM DOGGETT						HAME			
BE	19a. INFORMANT'S NAME (Type/Print)	11	9b. MAILING	AODRESS (St	eet and Number or Ruraf	Route Number	er, City or Town	n, State, Zip	Code)	341
9	THELMA GRAHAM		2207	HOME	WOOD AVE	ENUE,	BALTI	MORE .	, MD	21218
	20e_METNOD OF DISPOSITION 1 ABurlel 2 ☐ Cremetton 3 ☐ Removal from State			OF DISPOSITIO	N (Name of	DATE	20c. LO	CATION — C	City or To	wn, Sista
	1/L/Mouriel 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	GARD	EN of	ther place) FΔT	TH MEM. GA	RDENS	11_11	I RA	ITIM	ORE, MD
Ì	21. SIGHATURE OF FUNERAL SERVICE LICENSES	- I WIND	CIV OI		E AND ADDRESS OF F		***	DI	-111	IONE, HO
	Talpinte Dan	io		MM	. C. MARCI	H FH.	-1101	E. N	NORT	H AVENUE
	PART I. Enter the diseasea, or complications the	1 caused the d	eeth. Do r	not enter the	mode of dying, suc	ch aa cardi	ac or reapl	ratory arre	est,	Approximate
	shock, or heart failure. List only one cau #MMEDIATE CAUSE (Final						-			Onset and Death
	disease or condition	050 SC.	erot	10 (ardiovo	2 5 CM	lar	Disc	050	
ŀ	resulting in death) a. DUE TO	(OR AS A CONSI	EOUENCE O	F):	201 011010		- (0-1	4713		
2										
CERTIFICATION	Sequentially list conditions, If any, leading to immediate	(OR AS A CONSE	EOUENCE O	F):						
8	cause. Enter UNDERLYING									
Ĕ	CAUSE (Disease or injury that initiated events	(OR AS A CONSE	EOUENCE O	F):						
	resulting in death) LAST									
DICAL	PART II. Other aignificant conditions contributing to	death but not	reaulting	in the under	lying cause given in	n Part I.	24a. WAS AN PERFOR		24b	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO
용네							1 XYES 2			COMPLETION OF CAUSE OF DEATH?
ME							parti	al		1 YES 2 NO
-	DID TOBACCO USE CONTRIBUTE TO CA	USE OF DE	ATH YI	S NC	UNCERTAL	IN 🖾	,			
¥	25. WAS CASE REFERRED TO MEDICAL			TN (Check only						
PHYSICIAN:	EXAMINER? XIX YES 2 NO 1 Inpatient 2X	VER/Outpetient	3 □ DOA	OTHER:	Nome 5 Residence	6 🗆 Other	(Specific)			
¥	27. MANNER OF DEATN 28e. DATE OF		28b, TIN		INJURY AT	_	CRIBE HOW I	NJURY OCC	URED	
۵	1 Netural 5 Pending (Month, E			JURY	WORK?					
B⊀	2 Accident Investigation	F INJURY — At F	ome form			261 1 001	TION (Street a	and Alumbar	or Primi i	Druge Mumber
	3 Suicide 6 Could not be 4 Homicide determined	etc. (Specify)	tome, remi,	211991, 180101y,	01110	City o	r Town, State)	and reminder	OF THEMET	todio regridor,
COMPLETED	29a, CERTIFIER									
린	(Check only									
ő	2X MEDICAL EXAMINER: On the basis of a	xaminetion end/o	r Investigation	on, in my opin	on, death occured at the	e time, date	and place, an	d due to the	e cause(s) and manner as stated.
E	29b. SIGNATURE AND TITLE OF CERTIFIER	,			29c, LICENSE NU	JMBER		29d. DATE	SIGNED	(Month, Day, Year)
00	Dennis V. Chut	e mi			O.C.M	1.E.	. 1	OVE	MBE	R 6,1995
임	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAU	SE OF DEATH (IT	ЕМ 27) (Туре	, Print)						
	DENNIS CHUTE HD	11	1 Pe	nn St	reet, Ba	altim	ore,	Mar	yla	nd 21201
	3 NOW 1450 (Monte 995) Jaki 32. REGISTRI	AR'S SIGNATURE								
	1000 9 1995 Jalia Bridge	Rocky								
1	THUM We adding a									



OSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withing a hours after death. Page 6 may be retained by the hospital or attending physician.	1 THE FUNERAL DIRECTOR: After this centhicate has been signed by the artending physician and completely lined in by the funeral orector, page 3 should be detached not use as the bunlar-transin permit, rages 1, 2, 3 should filled within 72 hours after death with the State Dept. of Health and Mental Hydiene prior to bunlal, cremation, or removal.
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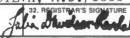
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

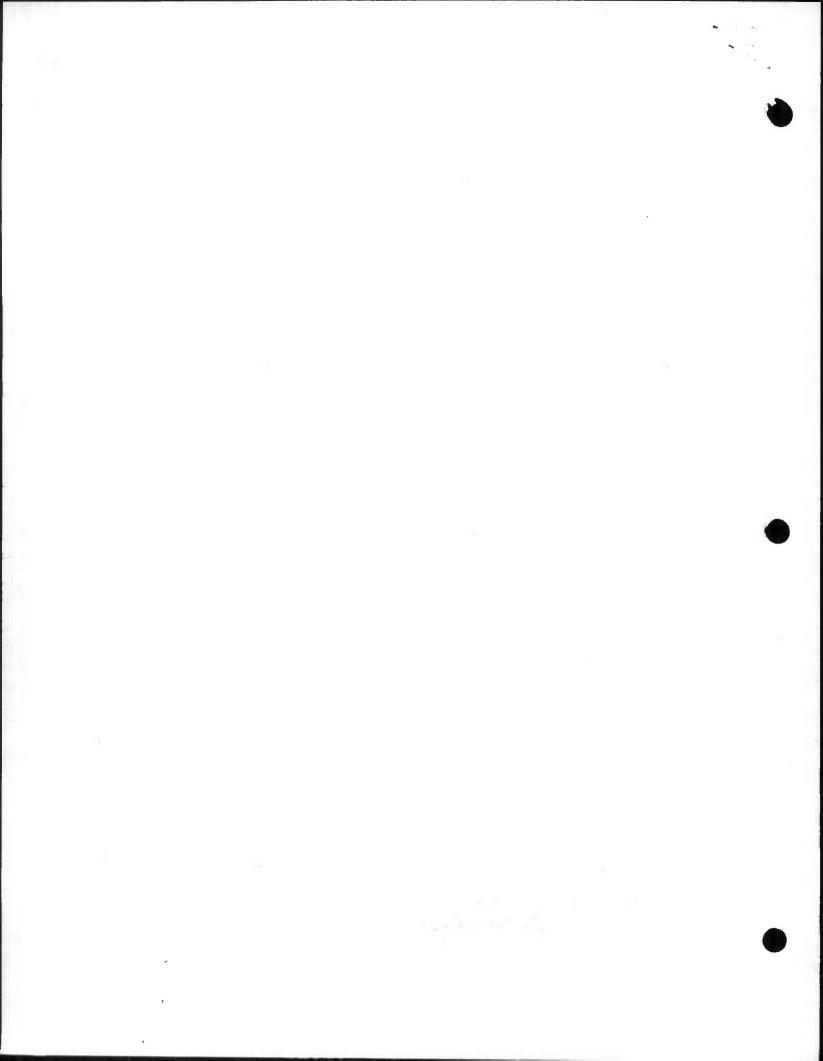
	1 - FOR STATE REGISTRAR	STATE OF N				HEALTH AND I	MENTAL HYGIEN REG. NO.		5 33840	
	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF DEATH	V V	3. TIME OF DEATN	
	GEORGE V	VILLIAM			HAHN		NOV.	7th	1995 05:32 PM	
	4. SOCIAL SECURITY NUMBER 295-38-5487	5. SEX	6. AGE (In yrs. In 48	est birthday) YRS.	IF UNDER 1 YEAR MONTHS DAY	7	7. DATE OF BIRTH (Month, Day, Year) 05-19-194	7 0	BIRTNPLACE (State or Foreign Country) PHIO	
	9a. FACILITY NAME (If not institution, give st	reet and number)			96. CITY, TOW	N OR LOCATION OF DI	EATN	9c. COUNTY OF DEATH		
TOR	NORTH ARUNDEL	HOSPITAL	ASSOCI	ATION	GLI	EN BURNIE		A	.A. COUNTY	
DIRECTOR	MARYLAND 10b. COUNTY		ARUNDEL	10c. CIT	Y, TOWN OR LO GLE	N BURNIE			10d. INSIDE CITY LIMITS? 1 YES 2XX NO	
FUNERAL	100. STREET AND NUMBER 1004 5TH STREET					101. ZIP COOE 21060		U.S.	N OF WHAT COUNTRY? A.	
BY FUN	11. MARITAL STATUS 1 Never Merried 2 X Merried 3 Widowed 4 Divorced	12. WAS DECEDEN FORCES? 1 IF YES, GIVE V 1966-	YES 2 WIR OR DATES		If yea,	DECENDENT OF NISPAI apocity Cuban, Mexico (ES 2X) NO Specific		or No —	I. RACE — American Indian, Black, White, atc. Specify: WHITE	
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	CATION completed) College (1-4 or 5	+) #	'Give kind of fe. Do NOT u	work done during se retired.) T R SERVI	most of working ECHNICIAN	BALTIMO		& ELECTRIC	
COM	17. FATNER'S NAME (First, Middle, Last) GEORGE WAL'	ΓER	HA	HN		18. MOTHER'S NA BEATRIC	E Girst, Middle, Melder	EAN"	BALTHAZAR	
TO BE	198. INFORMANT'S NAME (Type/Print) KATHY JANE HAHN		1	1004	ADDRESS (Stre	REET, GLE	Aoute Number City or Yow N BURNIE,	maryl?	ND 21060	
7	20g, METNOD OF DISPOSITION 1 🗓 Buriel 2 🗆 Cremation 3 🗆 Rame 4 🗎 Donation 5 🗀 Other (Specify)	oval from State			of disposition		1 2 / 1 0		y or Town, State NIE, MARYLAND	
	21. SIGNATURE OF FUREHAL SERVICE LIC	CENSEE			22. NAMI	AND ADDRESS OF FA		ON FUR	NERAL HOME, JRNIE 1061	
	23. PART I. Enter the diseases, or canonical shock, or heart failure.	complications the	it caused the	death. Do						
	IMMEDIATE CAUSE (Final disease or condition resulting in death)	a	OR AS A CONS	card	sal c	Infactio			Onset and Death	
CERTIFICATION	Sequentially list conditions, if any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	с.	OR AS A CONS							
MEDICAL C	PART II. Other eignificent condition						PERFO	RMEO?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	
	DID TOBACCO USE CONT	RIBUTE TO CA					N 🗆			
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 VES 2 NO	HOSPITAL:	/		OTHER:	ne)	6 Other (Specify)			
ВУ РНУ	27. MANNER OF DEATN 1 Netural 5 Pending Investigation	28a. OATE Of (Month, I	F INJURY Day, Year)	28b. Til	JURY	INJURY AT WORK? YES 2 NO	28d. DESCRIBE NOW	INJURY OCCU	RED	
ED	2 Accident srveningsrion 3 Suicide 6 Could not be detarmined		OF INJURY — At , etc. (Specify)	home, farm,	street, factory, o	office	26f. LOCATION (Street City or Town, State		Rural Route Number,	
COMPLET	(Critick only						a to the cause(a) and me e time, data and place, as		i. cause(a) and menner as stated.	
8	29b. SIGNATURE AND TITLE OF EATHER	Jest 1	~ M			2PC LICENSE NU	IMBER	29d. DATE	SIGNED (Month, Day, Year)	
5	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAL	ISE OF DEATH (II	TEM 273 (Turn	e Print)				1	

(Month, Day, Year) 3410 29d. DATE SIGNED 109 SYLVA, M.D./1600 CRAIN HIGHWAY, SW,
32. REGISTRAR'S SIGNATURE

January 1000 CRAIN HIGHWAY, SW, BURNIE, MARYLAND 2106 #302/GLEN

MICHAEL AV 31. DATE FILED (Month, Day, Yoar) NOV 0 91995





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fours after death. Page 6 may be retained by the hospital or attending pl	hould be detached for use as the bu	
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death.	letely filled in by the funeral director, page 5 sh	
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within	d completely	onor to burial, cremation, or
Jeg Peg	8	rial.
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BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within fours after death. Page 6 may be retained by the hoss TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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	Item1 11-9-9	5 FilmG	729 W.H.	Per	F/H					Q	5	33841
	1 - FOR STATE REGISTRAR	STATE OF N			TMENT (MENTAL HYGIEN	Ε	J	33041
	1. DECEDENT'S NAME (First, Middle, Last)	ock	Daniel						2. DATE OF DEATH MONTH DA	NA.	YEAR 95	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER 215-16-1261	5. SEX 1 🔀 M 2 🗌 F	6. AGE (In yrs. lest	birthday) YRS.	MONTHS D	EAR AYS	HOURS 1	HRS.	7. DATE OF BIRTH (Month, Day, Year) Dec. 29, 1		8. BIRTH Countr	PLACE (State or Foreign
OR	9a. FACILITY NAME (If not institution, give stre 2329 Sparrows		Rd		9b. CITY, TO		Edgem					eath timore
DIRECTOR	Maryland Maryland	Baltimo	ore	10c. CIT	Y, TOWN OR I	LOCAT	ION	Edg	gemere			10d. INSIDE CITY LIMITS? 1 YES 2 NO
FUNERAL	100. STREET AND NUMBER 2329 Sparrows Poi	nt Road				101.	ZIP CODE	21	219			vhat country? States
B⊀	11. MARITAL STATUS 1 Never Married 2 X Merried 3 Widowed 4 Divorced	12. WAS DECEDEN FORCES? 1] IF YES, GIVE W		WII	H ye	os, spe	city Cuban, A	HSPANI Mexican Specify:	C ORIGIN? (Specify Yea , Puerto Rican, atc.)	or No—	14. RACE Black Speci	- American Indian, t, White, etc.
COMPLETED	15. OECEDENT'S EDUCA (Specify only highest grade or Elementary/Secondary (0-12) 9 Years	ATION ompleted) College (1-4 or 5 +	(Gi	ve kind of a Do NOT us	usual occu work done duri se retired.)	ng mos	at of working		16b. KIND OF BUS			.y
BE CO	17. FATHER'S NAME (First, Middle, Last) Herbert W. Hancoc	ck							C. Lam	Surname)		
10	19a. INFORMANT'S NAME (Type/Print) Dennis Hancock		196						oute Number, City or Tow ad Edgema			land 21219
	20s. METHOD OF DISPOSITION 1X. Burial 2 CremeNon 3 Remov 4 Donation 6 Other (Specify)		20b. PLACE A cometery, created the Holly	nd date of the the the the the the the the the the	of Disposition ther plecel Mem.	Ga	lns. 1	1/1	0/95 Mic	ddle		vn, State
	· (had M.	ton			Du 79	da- 22	Wise	Fun Ave	eral Home Dundal	2. MD	21	
	23. PART I. Enter the diseases, or co shock, or heer fellure. Li IMMEDIATE CAUSE (Finel disease or condition resulting in death)	Meta DUE TO	static (OR AS A CONSEC	CCL A	nor (ratory am	eat,	Approximate Interval Between Onset and Death
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE 10	(OR AS A CONSEC	UENCE O	F):							
PHYSICIAN: MEDICAL CER	PART II. Other algorificent conditiona History of Asi COPD	contributing to	deeth but not ri	eouiting F.C.	in the unde	riying	cause give	en in F	Part I. 24a. WAS AN PERFOR	MED?	24b.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
/SICIAN:		HOSPITAL:	ER/Oulpatient 3	□ DOA	OTHER:		ACE OF DEAT		ck only one) Grant Cher (Specify)			
ED BY PH	27. MANNER OF DEATH 1 N Netural 5 Pending 2 Accident Investigation 3 Suicide 8 Could not be detarmined	28a. DATE OF (Month, D. 28a. PLACE O building,			M 1	WOI 1 🗌 Y	ES 2 N	ю	28d. DESCRIBE HOW II 28t. LOCATION (Street a City or Town, State)			loute Number,
COMPLETE	29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER:) and menner se stated.
TO BE C	296. SIGNATURE AND TITLE OPICEITH		14				29c. LICENS				SIGNED	(Month, Day, Year)

30. NAME AND ADDRESS OF PERSON

WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
20, MD 5505 Hopkins Bayinew Circle, Balt. Md 21224

31. DATE FILED (Month, Day, 1961)
NOV 09 1995 32. REGISTRAR'S SIGNATURE

DHMH-16 Rev 1/89



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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IMPORTANT: If them 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	FOR STATE REGISTRAR	STATE OF MARYLA		ENT OF HEALTH AND	MENTAL HYGIENE					
	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH		3. TIME OF DEATH			
	Dorothy Mae	Judd			NOVEWSE OR	1999				
	227 22 4715			NOER 1 YEAR IF UNDER 24 HRS.	7. DATE OF BIRTH	8.8	BIRTHPLACE (State of Foreign			
			56 YRS. MON	THE DAYS HOURS MIN.	JUN" 13 , 192	29 / 7	RVING, N.C.			
~	9a. FACILITY NAME (If not Institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DE									
DIRECTOR	Union Memorial Hospital Baltimore City n/a									
3EC	10a. STATE 10b. COUNTY		10c. CITY, TO			10d. INSIDE CITY				
	MARYLAND	n/a		BALTIMORE			Y LIMITS?			
FUNERAL	100. STREET AND NUMBER 4902 WILLIS	STON STREET		101. ZIP CODE 2122	9	OF WHAT COUNTRY? ED STATES				
N	11. MARITAL STATUS	12. WAS DECEDENT EVER IN L		13. WAS DECENDENT OF HISPA	UNIC ORIGIN? (Specify Year	or No.— 14. I	RACE — American Indian.			
	1 Never Married 2 Merried 3 XWIdowed 4 Divorced	FORCES? 1 YES		If yes, specify Cuban, Mexic 1 YES 2 XNO Spec	en, Puerto Rican, etc.)	- 1	Black, White, etc.			
D BY							Specify: BLACK			
TE	15. DECEDENT'S EDUCA (Specify only highest grade of	TION (npleted)	(Give kind of work of	one during most of working	16b. KIND OF BUSI	NESS/INDUST	RY			
PLE	Elementary/Secondary (0-12)	College (1-4 or 5+)	DOMESTIC	8 ₫.)	in ov	n ho	ome			
COMPLETED	17. FATHER'S NAME (First, Middle, Last)			40 MOTHER'S N	AME (First, Middle, Malden S		, m.c			
BE C	RICHMOND DAY	/IS		CHELL	ER SMITH	1				
2	190. INFORMANT'S NAME (Typo/Print) ZENOBIA WILL	IAMS	196. MAILING ADDI	RESS (Street and Number or Rural SPRINGDALE	Route Number, City or Town,	State, Zip Code	, MD 21207			
			LACE AND DATE OF DIS			ATION — City of				
	20s. METHOD OF DISPOSITION A Burial 2 Cremation 3 Remov 4 Donation 5 Other (Specify)	al from State cemete	ery, crematory or other pl	ace!	OATE 200. LOC		SCHOOL SECTION			
	21. SIGNATURE OF FUNERAL SERVICE LICEN		LITHORE	22. NAME AND AGORESS OF F		DALIII	1ORE, MD			
	Bernad D	Johnson					ORTH AVENUE			
	23. PART I. Enter the diseases, or co- ahock, or heart failure.	implications that caused t	he death. Do not en	nter the mode of dying, su	ch as cardiac or reapin	story arrest,	Approximate			
	IMMEDIATE CAUSE (Final	one cades on the					Interval Between Onset and Death			
	disease or condition resulting in death) a.	Acute Me	est faile	ue.			1.1.			
							A Elitha			
		DUE TO (OR AS A C	ONSEQUENCE OF):	. 0.00 (4)			1 clay			
NO	Sequentially list conditions,	DUE TO (OR AS A C	PNUL M	nonia			10 days			
ATION	Sequentially list conditiona, if any, leading to immediate cause. Enter UNDERLYING	Aspiration DUE TO (OR AS A C	PNUL MONSEQUENCE OF:	nonia			10 days			
IFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	DUE TO LOR AS A C Aspination DUE TO LOR AS A C Chip blasto DUE TO LOR AS A C	PNUM ONSEQUENCE OF):	nonia			10 days			
ERTIFICATION	Sequentially list conditiona, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	Aspiration Due to lor as a c Glioblusto	PNUM ONSEQUENCE OF):	nonia			10 days			
L CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	Aspiration DUE TO (OR AS A C DUE TO (OR AS A C	PNUM ONSEQUENCE OF): ONSEQUENCE OF):	uetiforme	Deci Lacana		3 years			
	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	Aspiration DUE TO (OR AS A C DUE TO (OR AS A C	PNUM ONSEQUENCE OF): ONSEQUENCE OF):	uetiforme	1 Part I. 24s. WAS AN A PERFORM	UTOPSY HED?	3 years 24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO			
	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	Aspiration DUE TO (OR AS A C DUE TO (OR AS A C	PNUM ONSEQUENCE OF): ONSEQUENCE OF):	uetiforme	1 Part I. 24a. WAS AN A PERFORM 1 YES 2]	IED?	24b. WERE AUTOPSY FINDINGS AMPLIABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?			
MEDICAL	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other aignificant conditions	Aspiruation DUE TO (OR AS A C OI D b Lusto DUE TO (OR AS A C	PNUL MONSEQUENCE OF): ONSEQUENCE OF): not resulting in the	nonia authiterme	PERFORM 1 YES 2	IED?	24b. WERE AUTOPSY FINDINGS AMPLETION OF CAUSE			
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	1. DECEDENT'S NAME (First, Middle, Las	·				2. DATE OF OEATN	V VE	3. TIME OF OEATN		
	1					Nov. 07,	1995	5:25 p		
	4. SOCIAL SECURITY NUMBER 213-74-9973	1 🗆 M 2 🗶 F)1 yas.	ONTHS DAYS		(Month, Day, Year) Sarch 24,	C	Hungary		
СТОВ	The state of the s	git Koralewski s. sex S. Sex								
5	RESIDENCE OF DECEDENT 10a. STATE 10b. COUN	ITY	10c CITY	TOWN OR LOCAT	TON			10d, INSIDE CITY		
DIRE	Maryland	Baltimore	100. 011,			re		1 YES 2 NO		
FUNERAL	928 Southwic	k Drive		101		86		USA		
B	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 TYES	2 NO	If yes, sp	ecify Cuban, Maxicar	, Puerto Rican, atc.)		RACE — American Indian, Black, White, etc. Specify: White		
ETED	15. DECEDENT'S El (Specify only highest gra Elementary/Secondary (0-12)	de completed)	(Give kind of wo	rk done during mo	ON st of working	16b, KIND OF BU	SINESS/INDUST			
<u> </u>	12		Homema	aker		Own H	ome			
COMPL	17. FATNER'S NAME (First, Middle, Last)				18. MOTHER'S NAI	ME (First, Middle, Maiden	Surname)			
i	Lajos P	okoly			Me1	anie Guz	man			
٤	196. INFORMANT'S NAME (Type/Print) Margaret Kah	1a								
	20a. METHOD OF DISPOSITION	206	PLACE AND DATE OF	DISPOSITION (No	ome of	DATE 20c LOCATION - City or Town State				
	1 Buriel 2 Xcremation 3 Removal from State Camelory, crematory or other place Metro Crematory, Inc. 11/09/95 Baltimore, MI									
	21. SIGNATURE OF FUNERAL SERVICE	M Donald	McDonald	Cre	mation So	ociety of				
CERTIFICATION	ahock, or heart fellure. List only one ceuse on eech line. Interior in the constant of the ceuse on eech line. Interior in the constant of the ceuse on eech line. Interior in the constant of the ceuse on eech line. Interior in the constant of the ceuse on eech line. Interior in the ceuse on eech line. Interior in the ceuse on eech line. Interior in the ceuse on eech line. Interior in the ceuse on eech line. Interior in the ceuse on eech line. Interior in the ceuse on eech line. Interior in the ceuse on eech line. Interior in the ceuse on eech line. Interior in the ceuse on eech line. Interior in the ceuse on eech line. Interior in the ceuse on eech line. Interior in the ceuse on eech line. Interior in the ceuse on eech line. Interior in the ceuse of the ceuse on eech line. Interior in the ceuse of the ceuse on eech line. Interior in the ceuse of the ceuse o									
-	PART II. Other algoriticent conditions	done contributing to death b	out not resulting in	the underlyin	g cause given in	PERFO	AMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
I. M	DID TOBACCO USE CON	ITRIBUTE TO CAUSE O	OF DEATH YES	□ NO K	UNCERTAIN			1 WES 2 NO		
SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEATH	(Check only one)						
Y PHY	27. MANNER OF DEATN 1 Natural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b, TIME	OF 28c. IN.	JURY AT		INJURY OCCUR	ED		
TED BY	2 Accident Investigation 3 Suicide 8 Could not in determined	28e. PLACE OF INJURY building, atc. (Soe	Y — At home, term, sti cify)	reet, factory, offic	10	281. LOCATION (Street City or Town, State	and Number or R	tural Route Number,		
COMPLET	compl.	YSICIAN: To the best of my know						usefal and manner as stated		
TO BE COMPLETED BY PHYSICIAN: MEDICA	290. SIGNADATE AND TITLE OF CENTRE	w St	Mu	0	D2233	IDEA	29d. DATE SIG	GNED (Month, Day, Year) . 09, 1995		
-	Joseph Zebley,		ork Road		, MD 2120	04				
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SICIAN, The law requires that the beam ceruincate be executed writing 24 hours after beath. Page o may be retained by the hospida of all	O THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.		IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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	FOR STATE REGISTRAR	STATE OF MARYLA							
	DECEDENT'S NAME (First, Middle, Lest)	Rubin Sea	ry Kiel			MONTH	DAY	YEAR	3. TIME OF DEATH 10:00A
	4. SOCIAL SECURITY NUMBER 217→22←4892	RUBBIT SEASY KIEL PRITY NUMBER S. SEX 22—4892	LACE (State or Foreign						
TOR	99. FACILITY NAME (If not institution, give to 31 02 Whiteway Residence of decedent								
DIREC			10c. CITY, TO	OWN OR LOCAT					10d. INSIDE CITY LIMITS? 1 YES 2 XNO
FUNERAL DIRECTOR	3102 Whiteway	Road		101		219	11.0		
B	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 V YES	2 NO	If yes, sp	olfy Cuban, Maxica	n, Puerto Rican,			- American Indian, White, atc.
COMPLETED	(Specify only highest grade Elementary/Secondary (0-12)	e completed)	(Give kind of work life. Do NOT use re	done during mo tired.)	st of working	16b. KIND			
COM	12 Years 17. FATHER'S NAME (First, Middle, Lest)		operaco	n Engl	18. MOTHER'S NA		, Maiden Surname)		
BE	Abner S. Kiel 190. INFORMANT'S NAME (Typo/Print)		19b. MAILING AD	DRESS (Street a				_	
2	Mrs. Teresa J.	Kiel							
	4 Donetion 6 Other (Specify)	novel from State com	stery cremetory or other	etery	11/8/19	95	Baltimo	re,	MD
	21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE	,						
-	23. PART I. Enter the diseases, or ahock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death)	Liet only one cause on ea	ich line.			h aa cardiac (or reapiratory and	reat,	Approximate interval Between Onset and Death
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	с		ence					
MEDICAL C	PART II. Other algnificent condition	na contributing to death be	ut not resulting in t	he UnderlyIn	g ceuse given in		PERFORMED?	24b.	WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
N: ME	DID TOBACCO USE CONT	RIBUTE TO CAUSE O	F DEATH YES	NO [UNCERTAI	N 🔲			1 YES 2 NO
SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	0	THER:	e & Manistance	6 Charles	noths)		
27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 26c. INJURY AT WORK? 28d. DESC								CURED	
TED BY	3 Suicide a Could not be	26a. PLACE OF INJURY building, atc. (Spec	— At home, farm, stre-	et, factory, offic	1			or Rural R	oute Number,
COMPLETED	0001	SICIAN: To the best of my knowl ER: On the bests of exemination							and menner as stated.
TO BE C	29b. SIGNATURE AND TITLE OF CERTIFIE # C \$ C C C C C C C C C C C C C C C C C	ALLZUM HO COMPLETED CAUSE OF DEA	ins	me)	DARSE NU				(Month, Day, Year)
	116	H ZOUM M	D 1205		ERE DE	2.550	S BALT	ON	1021204

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR

	REGISTRAR	CERTIF	ICATE OF	DEATH	REG. NO).					
	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH	aw.	3. TIME OF DEATH				
	DAVID Lawrence		KLEH	M			1995 7:25 PM				
		6. AGE (In yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7 DATE OF BURTH		B. BIRTHPLACE (State or Foreign				
1. DECEUD. 1. DECEUD. 1. DECEUD. 1. DECEUD. 1. DECEUD. 1. DECEUD. 1. DECEUD. 1. DECEUD. 1. DECEUD. 1. DECEUD. 1. DECEUD. 1. SOCIA. 1. SOCIA. 1. MARTI. 1. No. 3	215-58-3641 1 N M 2 🗆 F	47 YRS.	MONTHS DAYS	HOURS MIN.	April 20,1	948	Maryland				
	DECEDITY NAME (First, Modes, Last)	TY OF DEATH									
TOR	3306 LEVERTON AVENUE	DAVID Lawrence Barrier House (From Anished Land) DAVID Lawrence Barrier House (From Anished Land) DAVID Lawrence Barrier House (From Anished Land) DAVID Lawrence Barrier House (From Anished Land) Barrier House (Fro	N/A								
3	10e. STATE 10b. COUNTY	10c. CIT	Y, TOWN OR LOCAT	ON			10d, INSIDE CITY LIMITS?				
	Maryland N/A	B	altimore	, City			1 X YES 2 NO				
A	10e, STREET AND NUMBER		101	ZIP CODE		10g. CITIZ	EN OF WHAT COUNTRY?				
H H	3306 Leverton Ave.			21224	4		U.S.A.				
ב ב	FORGER 4					s or No—	14. RACE — American Indian, Black, White, etc.				
	IF YES, GIVE WA										
	15. DECEDENT'S EDUCATION				16b. KIND OF BU	SINESS/INDU					
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릴			OD DEPT		Superf	resh					
Š.	17. FATNER'S NAME (First, Middle, Last)			18. MOTHER'S NA	ME (First, Middle, Malden	Sumeme)					
	Adam L. Klehm			Jane G	. Russell						
	19a. INFORMANT'S NAME (Type/Print)	19b. MAILING	AOORESS (Street a	nd Number or Rural	Route Number, City or Tov	vn, State, Zip	Code)				
Ĕ	Mrs. Jane G. Gunderson	1716	N.E. 26	th. Terr	ace - Capr	Cora	1 , Fla. 33909				
		20b. PLACE AND DATE	OF DISPOSITION (Na	me of	DATE 20c. LC	CATION — C	lify or Town, State				
	4 Donation 5 Other (Specify)	Hilltop	Service	Corporat	ion 11/10/	/95 T	owson, Maryland				
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	//	22. NAME AN	D ADDRESS OF FA	CILITY						
	I wald to alekate	1.	Leon	ard J. K	uck runera	1 Hom	e, Inc.				
FICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury	IMMEDIATE CAUSE (Finel disease or condition resulting in death) ATHEROSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):									
E											
MEDICAL	PART II. Other aignificent conditions contributing to	feath but not resulting	In the underlying	cause given in	PERFO	RMED?	24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO				
ż	DID TOBACCO USE CONTRIBUTE TO CAL	JSE OF DEATH YE	ES 🗆 NO 🗆	UNCERTAI	N 🗆						
S		28. PLACE OF DEA									
S	TYTE										
	1 XNatural 5 Pending (Month, Da		JURY WO	RK?	28d. DESCRIBE HOW	INJURY OCC	URED				
ED BY	3 Suicide 28s. PLACE OF	INJURY — At home, farm, Mc. (Specify)	street, factory, offic	ı		281. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
	290. CERTIFIER										
COMPLETED	(Check only one) 2X XMEDICAL EXAMINER: On the basts of examiner.										
	AD SIGNATURE AND TITLE OF CERTIFIER	1		29c. LICENSE NU	MBER	29d. DATE	SIGNED (Month, Day, Year)				
BE	I HOUNG TOUR	41 11		0.C.	M E		EMBER 8. 1995				
2	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAU			W == 1			land 21201				
	11-14-16 - 1 CIG 1 00 OF 1	'S SIGNATURE	n stree	, Ddl	cimore,	нагу.	Lana ZIZUI				
	NOV 0 9 1995 July Divide	reliable									

Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020

director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should

TO BE COMPLETED BY FUNERAL DIRECTOR

DIVISION OF VITAL RECORDS P.O. BOX 68760

TO THE HOSPITAL DREATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hosp. TO THE FUNEFAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR	STATE OF MARY			HEALTH AND		BIENE I. NO.		
1. DECEDENT'S NAME (First, Middle, Las	Geraldine D.		.e	1	2. DATE OF DEA MONTH	DAY	YEAR	1:00 a.
4. SOCIAL SECURITY NUMBER 217-46-8044		E (In yrs. last birthday) 51 YRS.	IF UNDER 1 YEAR		7. DATE OF BIRTY (Month, Day, Y.	TN .		E (State or Foreign
90. FACILITY NAME (If not institution, give Holy Cross Hosp	street and number)			n or Location of E		9c. COU	l Inty of death tgomery	1
Holy Cross Hosp RESIDENCE OF DECEDENT 100. STATE 100. COUR Maryland Mont	gomery		lver Si					INSIDE CITY LIMITS?
	-	1 34	zvet sp	101. ZIP CODE 20910			S.A.	YES 2 NO
10. STREET AND NUMBER 8201 16th StA 11. MARITAL STATUS 1 [X] Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 YE IF YES, GIVE WAR OR	S 2 XHO	If yes	DECENDENT OF NISPA , specify Cuban, Maxic YES 2 X NO Spec	en, Puerto Ricen, el	Ify Yes or No-		merican Indian, Ita, etc., White
15. DECEDENT'S EI (Specify only highest gri Elementary/Secondary (0-12) 17. FATHER'S NAME (First, Middle, Last)	DUCATION de completed) College (1-4 or 5+)	16s. DECEDENT'S (Give kind of life. Do NOT u	work done during		16b. KIND C	OF BUSINESS/IN	DUSTRY	
17. FATHER'S NAME (First, Middle, Last)					AME (First, Middle, A Lutzky – &		th St.	
Jeanne Lutzky				eet and Number or Rura tApt.121				yland 209
20e. METHOD OF DISPOSITION 1 Buriel 2 Cremetion 3 Re 4 Donation 5 Other (Specify)		ob. PLACE AND DATE emetery, crematory or		(Nama of	DATE 2	9c. LOCATION -	- City or Town, S	Stata
21. SIGNATURE OF FUNERAL SERVICE	Male	ade, Dir.	Sta	E AND ADDRESS OF F Te Anatomi 3026-Balt				
IMMEDIATE CAUSE (Final disease or condition resulting in dasth) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	B. Respector	A CONSEQUENCE	OF):					2 week
PART II. Other algoriticant conditions of the co					1 1	VAS AN AUTOPSY ERFORMED? YES 2 NO	AVA CON OF	RE AUTOPSY FINDINGS ILABLE PRIOR TO APLETION OF CAUSE DEATH? YES 2 NO
DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 PNO 27. MANNER OF DEATN	HOSPITAL:	28. PLACE OF DE	OTHER:	one)				
	1 Empetiant 2 ER/O 28a. DATE OF INJUR (Month, Day, Year	Y 28b. TI	ME OF 28c	Home 5 Residence INJURY AT WORK? YES 2 NO	28d, DESCRIBE	**	CCURED	
2 Accident	28a, PLACE OF INJU	IRY — At home, farm, pecify)	t home, farm, street, factory, office 281. LOC			LOCATION (Street and Number or Rural Route Number, City or Town, State)		
Correct Gray	YSICIAN: To the best of my kn							d manner as stated.
296. SIGNATURE AND TITLE OF CENTRE	Lwo			29c. LICENSE N			TE SIGNED (MO	nth, Day, Year)
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31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SI	gnatuge ar labeled						

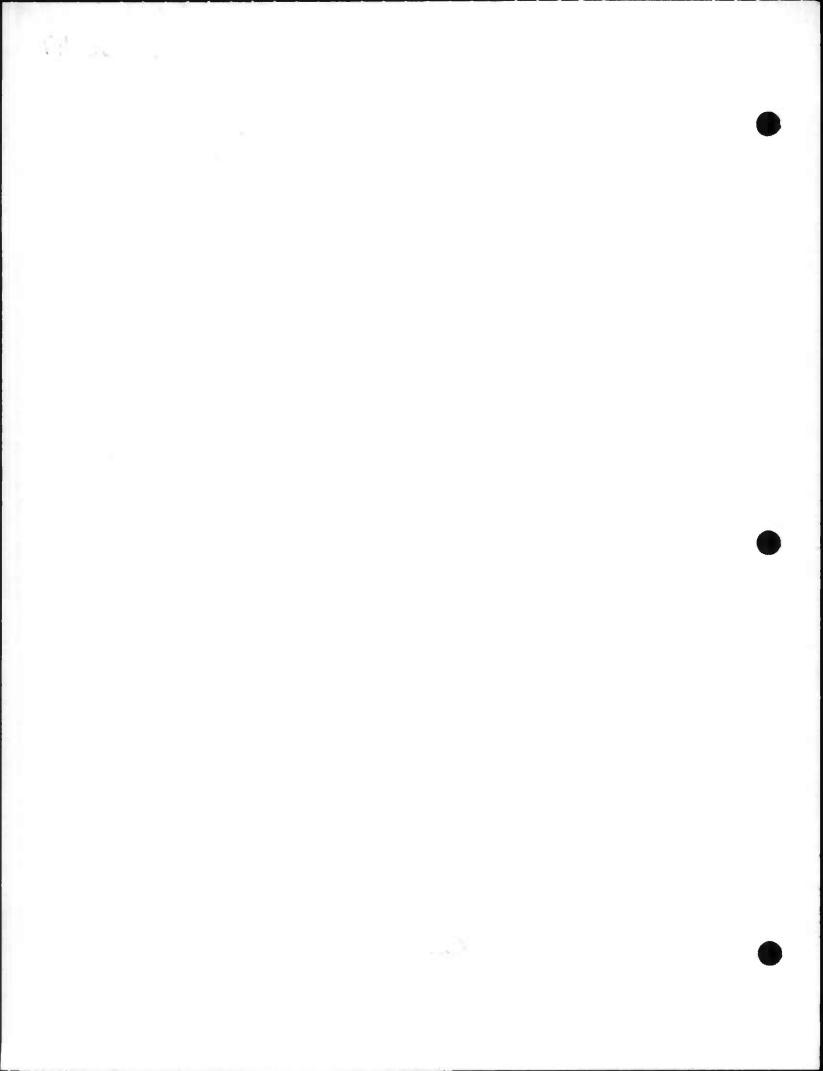
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CERTIFICATE OF DEATH REGISTRAR 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF GEATH 10:50 P. 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. last birthday) 7. DATE OF BIRTH BIRTHPLACE (State or Foreign 2/9 DAYS HOURS MIN. 1 M 2 KF YRS. Maryland Pages 1, 2, 3 should 9s. FACILITY NAME (If not institution, give street 9b. CITY, TOWN OR LOCATION OF DEATH Sc. COUNTY OF GEATH DIRECTOR **Pickersgill** Towson Baltimore RESIDENCE OF DECEDENT 10b. COUNTY 10a. STATE 10c. CITY, TOWH OR LOCATION 10d. INSIDE CITY LIMITS? Maryland Baltimore Towson 1 TES 2 NO permit. FUNERAL 10s. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 615 Chestnut Ave. use as the burial-transit 21204 U.S.A. retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 XNO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-If yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Merried Specify White BY 3 Wildowed 4 XDivorced COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY be detached for Elementary/Secondary (0-13) College (1-4 or 5+1 11 yrs. Secretary Dental 17. FATHER'S NAME (First, Mickelly, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) F Edward Thomas Dryden Emily Crosby BE notified page 5 should THE INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Pickersgill, Inc. 615 Chestnut Ave. Towson, Maryland 21204 Page 6 may be 9 29s. METHOD OF DISPOSITION 1 D Burlet 2 X Cremation 3 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must funeral director, Hillton Service Corp. 11/8/95 4 Donation 5 D Other (Spe Towson, Md. 21204 21. SIGNATURE OF OTHERAL SERVICE LICES examiner 22. NAME AND ADDRESS OF FACILITY death. 1050 York Road Ruck Towson Funeral Home, Inc. Towson, Md. un and completely filled in by the to burial, cremation and medical 23. PART I. Enter the dise es, or co ceused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory arrest, Approximeta shock, or heart fallure. Interval Betwe IMMEDIATE CAUSE (Final Onset and Death Brenst Concer the disease or condition TASTATIC event. resulting in death) DUE TO (OR AS A CONSEQUENCE OF). traumatic CERTIFICATION Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate the attending physician I Mental Hygiene prior to 2 cause. Enter UNDERLYING CAUSE (Disease or Injury certificate other DUE TO (OR AS A CONSEQUENCE OF)that initiated events reaulting in death) LAST 9 injury. PART II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 部 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE MEDICAL 24a. WAS AN AUTOPSY PERFORMED? by d that SITY pmentin Health a 1 TES 2 NO requires OF DEATH? Shows 1 YES 2 NO t, of H DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO K UNCERTAIN ICIAN: has b ME 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE DF DEATH (Check only one) 를 Hem certificate to the State HOSPITAL 1 YES 2 ATTENDING PHYSICIAN: PHYSI Inpetient 2 - ER/Outpatient 3 - DOA rsing Home 5 Residence 8 D Other (Specify) 5 the 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 26c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED marked, this with 1 Natural 2 Accident 5 Pending M 1 YES 2 NO After I BY 28s. PLACE OF INJURY — At home, term, street, factory, office building, atc. (Specify) 69 3 Suicide 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) ETED 6 Could not be DIRECTOR: hours after 4 Homicide 28 determined item item 8 29a. CERTIFIER COMPL 1 CERTIFYING PHYSICIAN: To the beat of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. TO THE HOSPITAL OF THE FUNERAL DE FILE WITHIN 72 M IMPORTANT: If IN (Check only one) 2 __ MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner as stated. 29c. LICENSE NUMBER BE 29d. DATE SIGNED (Month, Day, Year) 50 5 DEATH_(ITEM 27) (Type, Print) 6701 0 31. DATE FILED (Month, Day, NOV 0 91995



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TO THE HOSPITAL OR ATTENDING PHYS	2	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	2

	1 - STATE REGISTRAR	STATE OF M			RTMENT OF H	EALTH AND	MENTA	REG. NO.	E		
	1. DECEDENT'S NAME (First, Middle, Lest)	1.0			TOATE OF	DEATH	2. DATE MONTI	OF DEATH	×	YEAR	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER		SEBONE				1/	05	7	2	450 PM
	219 10 4894	5. SEX	8. AGE (In yrs. las	t birthday)	MONTHS DAYS	HOURS MIN.	(Monti	OF BIRTH n, Day, Year)		6. BIRTHE	PLACE (State or Foreign
	9a. FACILITY NAME (If not institution, give st		68	1110.	OF CITY TOWAL	OR LOCATION OF DE		05	27	Mar NTY OF OE	yland
DIRECTOR		ter-Bal	hmere		0 .1	gore	EAIN		Bec	Hin	N/A
EC	10a. STATE 10b. COUNTY	1		10c. CI1	TY, TOWN OR LOCAT	TION					10d, INSIDE CITY
HO	Maryland	N/A		Ba	ltimore						LIMITS?
AL	10e. STREET AND NUMBER	21/22				ZIP CODE			10g. CITI	ZEN OF W	HAT COUNTRY?
EB	2002 Girard	Avenue				212	11		U.S	S.A.	
FUNER.	11. MARITAL STATUS	12. WAS DECEDENT FORCES? 1	EVER IN U.S. AR	MED		ENDENT OF HISPAI			or No-	14. RACE	- American Indian, White, atc.
	1 Never Married 2 Married	FORCES? 1		10		ecity Cuban, Maxica 2 NO Specif		Rican, etc.)		Specify	
В	3 Widowed 47 Divorced					X					White
ED	15. DECEDENT'S EDUC (Specify only highest grade	CATION completed)	(G	ive kind of	Work done during mo	ON ist of working	16b	KIND OF BUS	HNESS/INC	USTRY	
LET	Elementary/Secondary (0-12)	College (1-4 or 5+) life.	. Do NOT u	ise retired.)		NT.	t- T- A.		- a- Ti	Iom I imag
MPI	8		Tru	ck D	river		N	orth A	meri	can v	an Lines
COMPL	17. FATHER'S NAME (First, Middle, Lest)					16. MOTHER'S NA			Surname)		
BE	Andrew Long:	iest				Margar	et M	arden			
5	19a. INFORMANT'S NAME (Type/Print)				,	and Number or Rural					1011
F	Zola Pemberton			2002	Girard	Ave., Ba	iltim	ore, M	aryla	and 2	.1211
	20a. METHOD OF DISPOSITION 1 X Burlal 2 Cremation 3 Ram	oval from State			OF DISPOSITION (N		DAT			City or Tov	
	4 Donation 5 Other (Specify)		Garri	son	Forest V			/95 Ow	ings	Mi11	s, Maryland
	21. SIGNATURE OF FUNERAL SERVICE LIC	CENSEE	10		22. NAME A	an Seitz	ACILITY	Fune	ro1 1	Home	
	1 Ca Cillan	Set	1/4								land 21211
	23. PART I. Enter the diseasea, or o	complications that	caused the de	ath. Do							Approximate
	ahock, or heart fallure.										Interval Between Onset and Death
	iMMEDIATE CAUSE (Finel disease or condition	Sea									John Carlo Saatii
	resulting in death)	· Schol	OR AS A CONSE	OUENOE 6	NE)-						
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ED BY PHYSICIAN: MEDICAL	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated eventa resulting in death) LAST PART II. Other significant condition LINAL GALLUR DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH Netural 5 Pending Investigation 3 Suicide 8 Could not be determined 29s. CERTIFIER (Check only 1 CERTIFYING PHYS)	DUE TO DUE TO CALL DE CONTRIBUTE TO CALL DE CONTRIBUTE TO CALL DE CONTRIBUTE TO CALL DE CONTRIBUTE TO CALL DE CONTRIBUTE TO CALL DE CONTRIBUTE TO CALL DE CONTRIBUTE TO CALL DE CONTRIBUTE TO CALL DE CONTRIBUTE TO CALL DE CONTRIBUTE TO CALL DE CONTRIBUTE TO CALL DE CONTRIBUTE TO CALL DE CONTRIBUTE TO CALL DE CONTRIBUTE DE CO	(OR AS A CONSECTION OF ICAL CONS	OUENCE COUENCE	ES NO E ATH (Check only one) OTHER: 4 Nursing Hor NURY M 1 street, factory, offined at the time, date	g ceuse given in UNCERTAI DIURY AT DIKY? YES 2 NO	6 Other	PERFOR t YES 2 PF (Specify) SCRIBE HOW I CATION (Street or Town, State)	NJURY OC	CURED or Rural R	WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
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ED BY PHYSICIAN: MEDICAL	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated eventa resulting in death) LAST PART II. Other significant condition PART II. Other signi	DUE TO DU	(OR AS A CONSECTION OF AS A CONS	OUENCE COUENCE	ES NO E ATH (Check only one) OTHER: 4 Nursing Hor NURY M 1 street, factory, offined at the time, date	g ceuse given in UNCERTAI DIVENTAL JURY AT DRK? YES 2 NO se and place, and du death occured at the	6 Other 28d. DE 28f. LOC City	PERFOR t YES 2 PF (Specify) SCRIBE HOW I CATION (Street or Town, State)	NJURY OC and Number	cured r or Rural R ted. he cause(a)	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Noute Number, and manner sa stated, (Month, Day, Year)
BE COMPLETED BY PHYSICIAN: MEDICAL	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated eventa resulting in death) LAST PART II. Other algnificant condition LIVAL CALLEY DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH Netural 5 Pending Investigation 3 Suicide 8 Could not be determined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINE 29b. SIGNATURE AND TITLE OF CERTIFIER PART II. Other algnificant condition 1 CERTIFYING PHYS 29b. SIGNATURE AND TITLE OF CERTIFIER PART II. Other algnificant condition 1 CERTIFYING PHYS 2 MEDICAL EXAMINE	DUE TO DUE TO CA	(OR AS A CONSECTION OF AS A CONS	OUENCE COUENCE	ES NO LATH (Check only one) OTHER: 4 Nursing Hor ME OF 28c. IN NURY M 1 street, factory, offli	g ceuse given in UNCERTAI ne 5 Residence JURY AT YES 2 NO ne and place, and du death occured at the	6 Other 28d. DE 28f. LOC City	PERFOR t YES 2 PF (Specify) SCRIBE HOW I CATION (Street or Town, State)	NJURY OC	cured r or Rural R ted. he cause(a)	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Noute Number,
E COMPLETED BY PHYSICIAN: MEDICAL	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated eventa resulting in death) LAST PART II. Other significant condition PART II. Other signi	DUE TO DUE TO CA	(OR AS A CONSECTION OF AS A CONS	OUENCE COUENCE	ES NO LATH (Check only one) OTHER: 4 Nursing Hor ME OF 28c. IN NURY M 1 street, factory, offli	g ceuse given in UNCERTAI ne 5 Residence JURY AT YES 2 NO ne and place, and du death occured at the	6 Other 28d. DE 28f. LOC City	PERFOR t YES 2 PF (Specify) SCRIBE HOW I CATION (Street or Town, State)	NJURY OC and Number	cured r or Rural R ted. he cause(a)	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Noute Number, and manner sa stated, (Month, Day, Year)
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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

ITEMS:	23	PART	I,	27,	PER	MEO	FILM	G-729	11/14/95	t.t
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1	FOR STATE REGISTRAR		STATE OF N	MARYLAN	ID / DEPAR			EALTH AND	MENTA	L HYGIENI REG. NO.	E			
	1. DECEDENT'S NAME (First, CLYDE	Middle, Lest)	GH	N	1CKANN				MONT	OF DEATH	5,19	YEAR	TIME OF DEATN	м
1	4. SOCIAL SECURITY NUMBER 217-50-0772		5. SEX 1 M 2 F	6. AGE (In)	rs. lest birthday) 8 YRS.	IF UNDER 1	DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE	OF BIRTH		. BIRTNPL	ACE (Store or Foreign	
	90. FACILITY NAME (If not ins							DR LOCATION OF DE	EATN		9c. COUNT	Y OF DEAT	гн	
3 1	RESIDENCE OF DEC	EDENT									DALI	IMOI	(E	
7 H	los. STATE	Balt:			- 1	y, town of Owing							LIMITS? YES 2 1 NO	
FUNERAL	13 Byway	Rd.					101	21117				A.	AT COUNTRY?	
	11. MARITAL STATUS 1 N Never Married 2 3 Divor	T EVER IN U YES	2 ANO	16	yes, sp	ENDENT OF HISPAI ecity Cuben, Mexico 2 ANO Specifi	an, Puerto		or No— 1	Black, V Specify:	American Indian, white, etc.			
COMPLETED	15. DECE (Specify only Elementery/Secondary (0-	DENT'S EDU highest grede	CATION completed) College (1-4 or 5		6e. DECEDENT'S (Give kind of life. Do NOT u	work done d sa retired.)	CUPATIO	ON st of working	168	Clean:	0.1.2			
<u>u</u> -	17. FATNER'S NAME (First, Mi Edward Jo	seph l	McKann						inia	Middle, Meiden Grace	Sumame) Ritz			
2	190. INFORMANT'S NAME (7) Mary McCar							ottstown				ode)		
- 11	20a, METHOD OF DISPOSITA 1 M Burlel 2 Crematio 4 Donation 5 Other		LACEAND DATE			me of L Park 1	1-8-1		ATION — CH					
- 11-	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Eckhardt Funeral Chapel 11605 Reisterstown Rd. Owings Mills										11			
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such se cerdiec or respiratory errest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) ATHEROSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (OR AS A CONSEQUENCE OF):									Approximate interval Betwee Onset and De				
IFICAL	Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST													
₹	PART II. Other algnificant conditions contributing to death but not resulting in the u						deriyin	g cause given in	Part i.	24s. WAS AN PERFOR	MED?	CO	ERE AUTOPSY FINDIN MILABLE PRIOR TO DMPLETION OF CAUSI F DEATN? YES 2 NO	
PHTSICIAN: MEDIC	DID TOBACCO U		RIBUTE TO CA		DEATH Y			UNCERTAI	NB	-				
2	EXAMINER?	MEDICAL	HOSPITAL:			OTHER	1:	ne 5 🖔 Realdence	e 🗆 Osb	er (Enseite)				_
	27. MANNER OF DEATN 1 [X] Natural 5	Pending	28a. DATE OF (Month, E	INJURY	28b. TIR		28c. IN.	JURY AT ORK?	_	SCRIBE NOW I	NJURY OCCU	RED		
ED BY	2 Accident Investigation 3 Suicide 8 Could not be determined 28e. PLACE OF II building, sto				URY — A1 home, lerm, stree1, lectory, office				281. LOCATION (Street and Number or Rural Route Number, City or Town, State)				te Number,	
COMPLETED	29a. CERTIFIER (Check only one) 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2 MEDICAL EXAMINER: On the basic of azamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) are									nd menner as stated	ı.			
	296. SIGNATURE AND TITLE	OF CERTIFIE	n 10					29c. LICENSE NU	IMBER		29d. DATE	SIGNED (N	fonth, Day, Year)	
10 86	30. NAME AND ADDRESS OF	PERSON W	1 Chut	M>	N (ITEM 27) / Nov.	O.C.M.E.				NOVEMBER 6,19) 5	
1	DENNIS CHI	ITE	4,703	111	Penn		eet	, Balt	imor	e. Ma	ryla	nd 2	21201	
	31. DATE FILED (Month, Day, NOV 0 9199		La Dinde	R'S SIGNAT	URE					out of ARSE				

. F . F . 0 [5]

LOR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physicial
ir 24 hours after de
death certificate be executed with
w requires that the
OR ATTENDING PHYSICIAN: The law requires that
R ATTENDING

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Nem 28 is marked, or Nem 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	REGISTRAR		CERTIF	ICALE	F DEATH	REG. NO).					
	1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH DAY YEAR 3. TIME OF DEATH											
	ARNOLD	MERMELSTEIN	I			NOVEMBER						
	4. SOCIAL SECURITY NUMBER		(In yrs. last birthday)	IF UNDER 1 YEA		7. DATE OF BIRTH		8. BIRTHPLACE (State or Foreign				
	220-07-7928	1 X M 2 D F	73 YRS.	MONTHS DAY	B HOURS MIN.	MAR. 1,19	922 MÄRYLAND					
	9e. FACILITY NAME (If not Institution, give	street and number)		96. CITY, TOW	N OR LOCATION OF D	EATH	9c. COUN	TY OF DEATH				
1 B	THE JOHNS HOPKIN	IS HOSPITAL		BALTIN	ORE CITY		N/A					
DIRECTOR	RESIDENCE OF DECEDENT											
			10c. CIT	Y, TOWN OR LO				10d. INSIDE CITY LIMITS?				
1	MARYLAND 100. STREET AND NUMBER	BALTIMORE		BAL'	FIMORE			1 TYES 2 NO				
FUNERAL	1 7 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			10f. ZIP CODE				EN OF WHAT COUNTRY?				
뿐	3408 MERRYVALE RO				212		USA					
3	1 Never Merried 2 Nerried	12. WAS DECEDENT EVER FORCES? 1 XYES	2 NO	13. WAS 1	DECENDENT OF HISPA apocity Cubon, Mexico (ES 2 NO Special	NIC ORIGIN? (Specify Year, Puerto Rican, stc.)	s or No—	14. RACE — American Indian, Black, White, etc.				
B∀	3 Widowed 4 Divorced	IF YES, OIVE WAR OR	WWII	10	rES 2 NO Specif	у:		Specify:				
<u></u>	15. DECEDENT'S ED		16a. DECEDENT'S	USUAL OCCUP	ATION	16b. KIND OF BU	SINESS (INDI	WHITE				
COMPLETED	(Specify only highest grad Elementary/Secondary (0-12)	completed) College (1-4 or 5+)	(Give kind of life, Do NOT u	work done during	most of working	TOO. KIND OF BO		The Control of the Co				
7	Community (0-12)	5+	PRINCE	PT !	Principal			CATION				
8	17. FATHER'S NAME (First, Middle, Last)		TRINCI			CITY OF		TMORE				
Ü	BENJAMIN	MERN	ÆLSTEIN		DOF			IIROWSKI				
0	19e. INFORMANT'S NAME (Type/Print)			Anneses /o-	et and Number or Sunt	Bouts Mumbes Charac Tou						
일	196. INFORMANT'S NAME (Type/Print) 196. MAILINO ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) MRS. EUNICE MERMELSTEIN 3408 MERRYVALE ROAD BALTIMORE, MD 21244											
	20e. METHOD OF DISPOSITION	20	b. PLACE AND DATE					ity or Town, State				
	1 Buriel 2 Cremation 3 Rer	noval from State	metery, crematory or o	ther placel								
1 1	OHEB SHALOM MEMORIAL PARK - 11-8-1995- REISTERSTOWN, MI											
	SOL LEVINSON & BROS., INC.											
Щ	IN/LUMMEN	MARIN		6010	REISTERS	STOWN ROAD	BALTI	MORE, MD 21215				
	23. PART I. Enter the diseases, or shock, or heart failure.	complications that cause	ed the death. Do r	not enter the	mode of dying, suc	h ss cardiac or reap	Iratory arre	st, Approximate Interval Between				
	IMMEDIATE CAUSE (Final											
	disease or condition a. Sensic 2 day											
	DUE TO (OR AS A CONSEQUENCE OF):											
Z	metartatic prostate adeno cave inoma ! 6 40											
CERTIFICATION	Sequentially list conditions, if any, isading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury calculate) a. Left lower extremity calculates a.											
5	CAUSE (Disease or injury a lett lower extremity cellulitis weel											
별	that initiated events resulting in death) LAST	DUE TO (OR AS	A CONSEQUENCE OF	F):	1:1			7 1				
1	Tosulting in death) LAST	d. Congi	estive h	east of	alure			1 weeks				
	PART II. Other algnificant condition	ns contributing to death	but not resulting	in the underly	dng cause given in	Part I. 24a, WAS AN	AUTOREV	24b. WERE AUTOPSY FINDINGS				
EDICAL					ang outer grown in	PERFOR		AVAILABLE PRIOR TO COMPLETION OF CAUSE				
						1 _ YES 2	M NO	OF DEATH?				
Σ	DID TODACCO LICE CONT	DIDLITE TO CALLES						1 TYES 2 NO				
PHYSICIAN:	DID TOBACCO USE CONT	KIBUTE TO CAUSE (26. PLACE OF DEA			N DA						
<u> </u>	EXAMINER?	HOSPITAL:		OTHER:	ne)							
1×S	1 YES 2 NO 27. MANNER OF DEATH	1 X Inpetient 2 ER/Out			ome 5 Residence							
	1 Natural 5 Pending	(Month, Day, Year)	26b. TIM	JURY	INJURY AT WORK?	28d. DESCRIBE HOW I	NJURY OCCL	JRED				
BY	2 Accident Investigation	An DIACE OF IN HUR	× 115-11		YES 2 NO							
8	3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJUR building, etc. (Spe	r — at nome, term, i	street, tectory, o	Mice	261. LOCATION (Street of City or Town, Stete)	end Number o	r Rural Route Number,				
로		ICIAN: To the beet of my know										
COMPL	one) 2 MEDICAL EXAMIN	ER: On the basis of examination	on end/or investigation	on, in my opinior	, death occured at the	time, date and place, en	d due to the	cause(s) end manner ee stated.				
Ш	296. SIGNATURE AND TITLE OF CERTIFIE	R			29c. LICENSE NUI	MBER	29d. DATE	SIGNED (Month, Day, Year)				
0 8	VIII Filven	~ MI			N261	9						
٢	30. NAME AND ADDRESS OF PERSON WI	10 COMPLETED CAUSE OF DE	EATH (ITEM 27) (Type,	, Print)			. 400	1, 100				
	Isaac E. SILV	ERMAN, M.	D. 600	N. Wolf	e Street 1	10 Tower	Batti	rember 7, 1995 more, MD 21287				
	31. DATE FILED (Month, Day, Year) NOV 09 1995	12. 9 0 STRAPS SA	AN PER				- 41	7 -12-07				
	NOV 09 1595	July 10 man	COL LA									
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DR ATTENDING PHYSIC	FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should within 72 hours after death with the State Dect. of Health and Mental Horiene prior to burial. cremation, or removal.	APORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HOSPITAL	TO THE FUNERAL I	IMPORTANT: If I

	FOR 1 - STATE REGISTRAR	STATE OF MARYLA		MENT OF A		MENTAL HYGIEN						
,	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH			TIME OF DEATH			
	Frank		MEISE		1	November 5			:27	D M		
	4. SOCIAL SECURITY NUMBER		In yrs. last birthday)	IF UNDER t YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	6. B	8. BIRTHPLACE (State or Foreign Country)				
ŀ	213-00-30-3	30	40 yrs.	MONTHS DAYS	HOURS MIN.	Aug.		Mar	yland			
OR	90. FACILITY NAME (If not institution, give stree Franklin Squal		1		OSSVI116		Baltim					
딦	RESIDENCE OF DECEDENT 10a, STATE 10b, COUNTY		10c. CITY	TOWN OR LOCA	TION			104	I. INSIDE CITY			
DIRECTOR	Md. R	altimore		Middle River					LIMITS?	10		
	10e. STREET AND NUMBER	ar or more			I. ZIP CODE		10g. CITIZEN	OF WHA				
EH	3500 Honeysu	ckle Lane			2	1220	Ţ	JSA				
BY FUNERAL	11. MARITAL STATUS 1	2. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2 NO	If yes, sp		IIC ORIGIN? (Specify Yenn, Puerto Rican, etc.)		RACE — Black, W Specify:	American Indian			
G	15. DECEDENT'S EDUCA' (Specify only highest grade co	TION	16a. DECEDENT'S			16b. KIND OF BU	SINESS/INDUST	RY	***************************************			
COMPLETED		College (1-4 or 5+)	life. Do NOT us	,								
MPI	12th		Sec	urity	Gaurd	Se	curity	7				
00	17. FATHER'S NAME (First, Middle, Last)					ME (First, Middle, Malden						
BE	Henry Meise					a Laubac						
0	190. INFORMANT'S NAME (Type/Print) Dixie Meise					Route Number, City or Tow Lane Bal			2122	1		
	20e. METHOD OF DISPOSITION	20b	PLACEANDDATEO				CATION — City					
	Buriel 27 Cremation 3 Removel from State Commetter, crematory or other place) Metro CrematoryInc. 11/10/95 BAltimore MD.											
	21. SIGNATURE OF FUNERAL SERVICE LICEN	ISEE		22. NAME A	ND ADDRESS OF FA	CILITY						
	* R TIME	16	11.			neral Ho						
	23. PART I. Enter the diseases, or so	plicetions that ceused	the deam. Do n			e. Balti			Approximat			
	shock, or heart feilure to	only one cause on e	sch line		, , , , , , , , , , , , , , , , , , , ,		,		Interval Bet Onset and	tween		
	iMMEDIATE CAUSE (Final disease or condition	Atheroscler	otic Car	diovasc	ular Dis	ease			Unknow	110000		
	DUE TO (OR AS A CONSEQUENCE OF):									7n.		
Z	Compatibility list conditions b.											
VIIC	If sny, leeding to immediate											
2	CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF):											
CERTIFICATION	that initiated events resulting in death) LAST											
	DARKE II. OAL on all relations and distance							1				
SAL	PART II. Other significent conditions	contributing to deeth b	ut not resulting i	n the underlyir		PERFORMED?			0			
MEDIC						1 🖂 YES	2 ▼ NO	OF	MPLETION OF CA			
ž	DID TOBACCO USE CONTRI	BLITE TO CALISE O	E DEATH VE	s II NO I	UNCERTAI			1.[YES 2 N	0		
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEAT			I DE I			-	-		
Sici	EXAMINER?	HOSPITAL: I ☐ Inpatient 2 1℃ ER/Outp	netient 3 □ DOA	OTHER:	no E Beeldones	6 Other (Specify)						
HYS	27. MANNER OF DEATH	28e. DATE OF INJURY	28b. TIM	E OF 28c. IN	JURY AT	28d. DESCRIBE HOW	INJURY OCCUR	ED				
	1 Natural 5 Pending	(Month, Day, Year)	INJ		YES 2 NO							
D BY	2 Accident Investigation 3 Suicide 8 Could not be	26s. PLACE OF INJURY building, etc. (Spec	— At home, ferm, s	treet, factory, offi	0	261. LOCATION (Street City or Town, State		Bural Rout	e Number,			
TED	4 Homicide determined	Salienty, ster (Spec				City or lowit, State	,					
COMPLET	29a. CERTIFIER (Check only 1) CERTIFYING PHYSICI											
S S	one) 2 MEDICAL EXAMINER:	On the basis of examination	n and/or investigatio	n, in my opinion,	death occured at the	time, data end place, a	nd due to the ce	use(s) er	nd menner ee at	ited.		
ш	296. SIGNATURE AND SITLE OF CERTIFIER	1 1110	ah.		29c. LICENSE NUI	MBER			onth, Day, Year)			
TO B	There is	Sepamethe M			D2536	3	Nov	embe	r 5,199	95		
F	30. NAME AND ADDRESS OF PERSON WHO Mark Himmelheb				e Dr. R	alto, Md.	21237					
	31. DATE FILED (Month, Day, Year)				2							
	NOV 0 91995	32. REGISTRAR'S SIGN	bertadell									
		-										

) THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	T III	72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	MPORTANT: it item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HOSPITAL OR ATTENDIN	TO THE FUNERAL DIRECTOR; After	be filed within 72 hours after dea	IMPORTANT: If item 28 is n

	1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPARTM CERTIFICA			ENTAL HYGIENE REG. NO.					
	1. DECEDENT'S NAME (First, Middle JOAN	MARY		MAVI	S	2. DATE OF DEATH DAY NOVEMBER 8,	1995	3. TIME OF DEATH 7:07 P. M			
	4. SOCIAL SECURITY NUMBER 217-36-4799	1 🗆 M 2 😿 F	55 YRS. MO	UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 2-24-1939	Count	HPLACE (State or Foreign			
	99. FACILITY NAME (If not institution, give street and number) 478 MOUNTAIN ROAD 96. CITY, TOWN OR LOCATION OF DEATH CROWNSVILLE 96. COUNTY OF DEATH ANNE ARU										
OIL O		COUNTY ANNE ARUNDEL		OWN OR LOCAT				10d. INSIDE CITY LIMITS? 1 YES 2 NO			
TENAL I	100. STREET AND NUMBER 478 MOUNTAIN R	ROAD		101	21032		-	what country?			
	11. MARITAL STATUS 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. WAS DECEDENT EVER II FORCES? 1 YES IF YES, GIVE WAR OR D	2 X NO	If yee, sp	ENDENT OF HISPANI ecity Cuben, Mexican 2 X NO Specify:			E — American Indian, sk, White, etc.			
100		T'S EDUCATION est grade completed) College (1-4 or 5+) N/A	16a. DECEDENT'S USL (Give kind of work life. Do NOT use re OFFICE MA	done during mo tired.)		166. KIND OF BUSIN		ST			
E COM	17. FATHER'S NAME (First, Middle, INICHOLAS		POSEDEN		16. MOTHER'S NAM	E (First, Middle, Maiden Su		WANN			
2	190. INFORMANT'S NAME (Typo/Pri JOHN W. MA	AVIS, JR.				LERSVILLE,		.08			
20c. METHOD OF DISPOSITION 1 X Burles 2 Cremetation 3 Removed from State 20b. PLACE AND DATE OF DISPOSITION (Name of 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reepiratory errest, interval B onset and disease or condition resulting in death) Due To (or AS A CONSEQUENCE OF):											
NO INCIDIO	Sequentially list conditione, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST BRAIN CETTA STASES DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):										
MEDICAL OF	PART II. Other aignificant co	onditions contributing to death t	but not resulting in t	he underlyin	g ceuse given in I	Part I. 24a, WAS AN AN PERFORM	ED3	b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?			
HTSICIAN. W	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)										
FILT	1 VES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pendi			F 28c. IN.	JURY AT DRK? YES 2 NO	8 Other (Specify) 28d. DESCRIBE HOW INJ	JURY OCCURED				
ובט פז	3 Suicide 6 Could	28e. PLACE OF INJUR' building, etc. (Spe	Y — At home, ferm, etre-			281. LOCATION (Street en City or Town, State)	and Number or Rural Route Number,				
COMPLE	one)	(Check only 1 CERTIFTING PHYSICIAN: 10 the best of my knowledge, death occurred at the time, date and place, and due to the cause(e) and manner as stated.									
0 00 0	296. SIGNATURE AND TITLE OF C	Thaveuk	M.D.		29c. LICENSE NUM D361	96 46	29d. DATE SIGNE	(Month, Day, Year)			
	30. NAME AND ADDRESS OF PER KATHERINE 31. DATE ELED (Month, Paywork)	ISON WHO COMPLETED CAUSE OF DI TWA CZUK ME 32. EGISTATS S	EATH (ITEM 27) (Type, Pri		UTHGRE	ENE ST J	BAUTIN	COREMDZIA			
	NUV 0 91995) July dhudsark	well								

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10 THE MOSFILE, UN ALTENDING PRINCIPAL ALTERIANDED FOR THE LANGE OF THE LANGE OF THE LANGE OF THE MOSPILE OF THE LANGE OF		nsit permit. Pages 1, 2, 3 should	
10 THE NOSPITAL DR AT ENDING PROSECUE. THE law requires that the beat centure of executor when 24 hours after beat of relative by the mospital or no the FUNEAL DIRECTOR, After this certificate has been signed by the attending physician and complety filled in by the funeral director, page 5 should be detached for up to filled the first beath with the State Dept. of Health and Mental Hydgine prior to bring, or entinoral. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	diterioring proysician.	ise as the burial-trai	
TO THE FUNERAL DIRECTOR: After the filed within 72 hours after death view PAPATANT: If item 28 is mark	SICIAN: THE IAM TEQUIES UTAL THE DEATH CELLITICATE OF EXECUTED WITHIN A	his certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as a vith the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	ted, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
	OH ALIENDING	TO THE FUNERAL DIRECTOR; After be filed within 72 hours after death	=

	FOR 1 STATE	STATE OF N	MARYLAND A					MENTAL	HYGIEN	E E		, , , , , ,
	REGISTRAR 1. DECEDENT'S NAME (First, Middle, Last)		С	ERTIF	ICATE (OF DEA	TH	O DATE	REG. NO.	-	Ι.	THE OF PETT
	Richard E.	Miller						MONTH	ember		YEAR / 995	12:00 PM
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. la		IF UNDER 1 YE		R 24 HRS.	7. DATE OF BIRTH 8. BII (Month, Day, Year) Co.			8. BIRTHPL Country)	ACE (State or Foreign
	170 11 1373	1 X M 2 □ F	58	YRS.				May	04, 1			Iowa
H	9a. FACILITY NAME (If not institution, give st		HOSP:4	20 -		wn or locat Ltimo:					NTY OF DEA	TH
5	RESIDENCE OF DECEDENT		7 0 40 1 7	140				101				
DIRECTOR	Maryland N	/ A		10c. CIT	Y, TOWN OR L		timo	re				Od. INSIDE CITY LIMITS? X YES 2 NO
FUNERAL	100. STREET AND NUMBER 642 Gorsuch A	venue			** * *	10f. ZIP CO	212	218		10g. CIT.	US	AT COUNTRY?
BY FUNE	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDEN FORCES? 1 IF YES, GIVE W	MAR OR DATES		If ye	DECENDENT s, specify Cub YES 2 XIC	an, Mexica	n, Puerto F		or No-	Specify:	- American Indian, white, etc.
	15. DECEDENT'S EDUC	CATION	- 1		USUAL OCCU	PATION		16b.	KIND OF BU	SINESS/1NI		WILLOC
COMPLETED	(Specify only highest grade Elementary/Secondary (0-12) 1 2	(6	Give kind of v e. Do NOT us	vork done durin	g most of work			Navy				
COM	17. FATHER'S NAME (First, Middle, Last) Carroll William Miller Carsol William Miller Carsol William Miller									222		
BE		willian										
2	Denene Renee		ARLING ADDRESS (Street and Number or Rural Pouls Number, City or Town, State, Zio Code) O. Box 1315 Fall City, WA 98024									
	20a. METHOD OF DISPOSITION 1 □ Burla1 2X□ Cremation 3 □ Remo	AND DATE	of Dispositio	N(Name of	. 1	1/07			imore	, State		
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE Dawn				remati		CILITY,	tre of	Moxxx	land	Tno
	Dawn F.1	MCNo	nold									D 21228
	23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart fellure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition as End 3+age A 1 D S DUE TO (OR AS A CONSEQUENCE OF):							Approximate Inferval Between Onset and Death				
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in deeth) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF):											
PHYSICIAN: MEDICAL C			g in the underlying cause given in Part i. 24s. WAS AN AUTOPSY PERFORMED? 1 □ YES 2 1 NO				a d	VERE AUTOPSY FINDINGS WAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? YES 2 NO				
AN	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO W UNCERTAIN 28. PLACE OF DEATH (Check only one)											
CI	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			OTHER:							
ΗXS	1 Tes 2 NO 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 8 Other (Specify)								CURED			
BY PI	1 Netural 5 Pending 2 Accident Investigation	IN.	M 1	WORK?	□ NO	28d. DESCRIBE HOW INJURY OCCURED						
	3 Suicide 6 Could not be 4 Homicide determined	ome, farm,	farm, street, factory, office 281. LOCATION (Street and City or Town, State)						d Number or Rural Route Number,			
COMPLETED	(Orlock Only	(Check only 1 DK CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.										and manner as stated.
BE CO	2011. SIGNAPLINE AND TITLE OF CENTIFIER	7	n	29c. LICENSE NUMBER ATZ438				ER 29d. DATE SIGNED (Month, Day, Yea			Month, Day, Year)	
5	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAN	SE OF DEATH (IT	EM 27) (Type	, Print)		1 24	587	76	,	16/	47
	Pat me Ki	NOCU REPORTE	Unio	nm	roms	ialt	4056	ital	B	alti'v	nor	e, mdi
	NOV 0 9 1995 A	d'en les	Vanis .				,					

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page A should be detached for use as the bunial-transit permit. Pages 1.	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: if item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the de	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the a	be filed within 72 hours after death with the State Dept. of Health and Merri	IMPORTANT: if item 28 is marked, or item 23 shows any injury

	1 - STATE REGISTRAR					CATE OF			REG. NO.				
	1. DECEDENT'S NAME (First, Middle,	, Lest)						2. DATE	OF DEATH		YEAR	3. TIME OF DEATH	
	GEORGE		FRANCIS		MOI	RAIS			Nov 6	1995		4:15 pm i	
	4. SOCIAL SECURITY NUMBER 212-12-3301		1 🔀 M 2 🗆 F	NGE (In yrs. lesi	t birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	Sep. 10, 1911		8. BIRTH Countr	PLACE (State or Foreign y) Md.		
	90: FACILITY NAME (If not institution Saint Joseph RESIDENCE OF DECEDER	Med					vaon, Mar						
DIRECTOR	10a. STATE 10b. C	OUNTY	timore		10c. CITY	town or Local						10d. INSIDE CITY LIMITS? 1 YES 2 NO	
LONEHAL	100. STREET AND NUMBER 204 Morris Ave				ZIP CODE			17	S.A	VHAT COUNTRY?			
BY PUN	11. MARITAL STATUS 1 ☐ Never Merried 2 ☐ Merried 3 ☐ Widowed 4 ☐ Divorced 12. WAS DECEDENT EVER IN FORCES? 1 ☐ YES IF YES, GIVE WAR OR DA'			YES 2 XN		If yes, sp	ENDENT OF HISPAI ecify Cuben, Maxice 2 XNO Specif	n, Puerto I	i? (Specify Yes Rican, etc.)	or No—	14. RACE Bisch Speci	- American Indian, t, White, etc.	
COMPLEIED	15. DECEDENT (Specify only highes Elementary/Secondary (0-12) 12	'S EDUC	ATION completed) College (1-4 or 5+)	(Gi life.	ive kind of w Do NOT us		st of working	16b	State				
										ınt			
2	19b. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Nellie L. Morris 204 Morris Ave. Lutherville, Md. 21093 20b. PLACE AND DATE OF DISPOSITION DATE 20c. LOCATION — City or Town, State												
	20e. METHOD OF DISPOSITION 1 Burlel 2 □ Cremetion 3 □ 4 □ Donation 6 □ Other (Specify	y)				her place) S Cemet	ery 11/	10/95	De:	lmar,	Del	wn, State Laware	
	21. SIGNATURE OF FUNERAL SERV		Towson York Rd										
	immediate cause (final disease or condition as GASTROINTESTINAL BLEEDING as GASTROINTESTINAL BLEEDING										Approximate interval Between Onset and Deati		
CERTIFICATION	DUE TO (OR AS A CONSEQUENCE OF): ACUTE MYELOGENOUS LEUKEMIA DUE TO (OR AS A CONSEQUENCE OF): ACUTE MYELOGENOUS LEUKEMIA DUE TO (OR AS A CONSEQUENCE OF): C. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):										9 МОЯТН		
THE SICIAIN. INEDICAL	PART II Other plantitions contributions contributions to death but not condition to the underlying and the Book I are underlying to death but not condition to the underlying										. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO CDMPLETION OF CAUSE OF DEATH? 1 YES 2 0		
IMIX.	DID TOBACCO USE C	ICAL		26. PLAC	E OF DEAT	H (Check only one)	UNCERTAL	N□					
	EXAMINER?		HQSPITAL; 1 □Mopatlant 2 □ ER	/Outpetlant 3	□ DOA	OTHER: 4 Nursing Hon	e 5 Residence	6 🗆 Othe	ir (Specify)				
מו בעו	27. MANNER OF DEATH 1 Setural 5 Pending Investigation 26e. DATE OF INJURY (Month, Day, Year)									IBE HOW INJURY OCCURED			
	3 Suicide 6 Could 6 4 Homicide detarmi		26s. PLACE OF IN- building, atc.	JURY — At ho (Specify)	me, farm, s	treet, fectory, offic	â		ATION (Street or Town, Stelle)		or Rural i	Route Number,	
COMPLETED	Torroom ormy	A	CIAN: To the best of my									and menner ee steted.	
	296. SIGNATURE AND TITLE OF CE	HTIFIER	110 /	37	>		29c. LICENSE NU			29d. DATE	SIGNED	Month Say, Jose	

M.D., 7505 OSLER DRIVE, SUITE 504, TOWSON, MARYLAND 21204

RICHARD L. HUSLIG,
31. DATE FILED (Month, Day, Year)
NOV 0 91995 July

그는 그는 생기 의원이다. 지나 가는 것이나라면 기본하나요. 그만만

	SALLIMORE, MARTLAND ZIZIS-0020
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely fille	ed in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should
be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation,	filed within 72 hours after death with the State Degr. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	medical examiner must be notified at once.

	1 - STATE REGISTRAR	SIAIE UF I	MARYLAND / I CE				DEAT		MENT	AL HYGIEN REG. NO.	E		
	1. DECEDENT'S NAME (First, Middle, La	(st)							2. DA	TE OF DEATH	-		3. TIME OF DEATH
	Richard			N	UKOL	C7 AK			MO	vember		995	10:30 p.
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. lest		IF UNDER	1 YEAR	IF UNDER	24 HRS.	7 DA	TE OF BIRTH		a BIRTI	MRI ACE /Plain on Familian
	215-12-993	7 1 💢 M 2 🗆 F	☐ F 72 YRS. MONTHS C			DAYS	HOURS	MIN.	Feb. 19, 19		923	Ma	ryland
	Sa. FACILITY NAME (If not institution, gi	Ba. FACILITY NAME (If not institution, give street and number)			9b. CITY	TOWN C	R LOCATIO	ON OF DE			Y	JNTY OF D	
DIRECTOR	Franklin S	spita1			R	loss	vil'	10		Ra1	timo	re	
5	RESIDENCE OF DECEDENT 10a. STATE 10b. COU												
<u>E</u>	Md.		timore Middle					Dimen				10d. INSIDE CITY LIMITS?	
	10e, STREET AND NUMBER	Dai	cimore									1 YES 2 NO	
R	1103 Middle	away Poa	4	1 10f. ZIP CODE 212					HITTI CONT.				WHAT COUNTRY?
FUNERAL	11. MARITAL STATUS	T EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC								USA			
	1 Never Married 2 Married	YES 2 NO)		If yes, sp	ecify Cuba	n, Maxica	n, Puari	io Rican, etc.)	or No —	Blac	E — American Indian, ik, Whita, etc.	
BY	3 Widowed 4 Divorced	0.0	1 11	1 120 30 110 4,000,00					Spec			White	
COMPLETED	15. DECEDENT'S 8 (Specify only highest gi	DUCATION	16a. DEC	EDENT'S	USUAL O	CCUPATIO	N st of workin	_	1	6b. KIND OF BUS	SINESS/IN	DUSTRY	WIIILE
	Elementary/Secondary (0-12)	College (1-4 or 5	Hin I	Do NOT u	se retired.)	ourny mo	St OF WORKIN	v					
MP		2yr:	S	Iron Worker						n/	a		
8	17. FATHER'S NAME (First, Middle, Last)					16. MOTH	IER'S NAI	ME (Fire	t, Middle, Maiden	Sumame)			
B	<u>unknown</u> unknown												
2	19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)												
	Carrie Nukolczak 1103 Middleway Road Baltimore Md.21220												
)	20a. METHOD OF DISPOSITION 1 General 2 The mention 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of cametery, crematory or other place) 20c. LOCATION — City or Town, State 20c. LOCATION — City or Town, State Metro Crematory Inc. 11/9/95 Baltimore Md.												
	21. SIGNATURE OF FUNERAL SERVICE	LICENSEF	Metro	Cr			Inc.			95 Ba1	tim	ore	Md.
	DT	//	1	1						1 17.			
	1. Lu	14 10	mell	14		Onn	err?	r L	ine	ral Ho	me	OI I	SSEX
ľ	23. PART I. Enter the diseases, a shock, or heart fellur	or complications the	t coused the desi	th. Do r	not enter	the mo	de of dyl	ng, áuci	n sa ci	rdiac of reapi	ratory ar	rest,	Approximate
	IMMEDIATE CAUSE (Final	,		/									Onset and Death
	disease or condition	Seps	12										
	disease or condition resulting in death) Due to (or as a consequence of): Severe Covernment on here disease												
ON	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events Severe Coronary on hery disease. Due to (or as a consequence or): Confestive heart failure (end stage). Due to (or as a consequence or):												
CERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING Confestive heart fuller (end stage).												
윤	CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF):												
F	resulting in death) LAST d. D. a better M. III has												
2	PART II. Other significent conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS												
CAL	PARI II. Other significent condit	ions contributing to	deeth but not rea	eulting i	in the un	derlying	ceuse g	iven in	Part I.	24a. WAS AN PERFOR		24b	. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
ă										1 TES 2	NO		COMPLETION DF CAUSE OF DEATH?
MED									٠.				1 YES 2 NO
ä	DID TOBACCO USE CON						UNC	ERTAIN	1/2				
o l	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE		OTHER	-							
PHYSICIAN:	1 TYES 2 NO		ER/Outpetient 3					eldence		her (Specify)			
	1 Natural 5 Pending	28e. DATE OF (Month, D		28b. TIM INJ	URY	28c. INJU WOI	RK?		28d. D	ESCRIBE HOW IN	IJURY OC	CURED	
À	2 Accident Investigation		F INJURY — Al home			1 🗆 Y		NO					
	3 Suicide 8 Could not i	building.	etc. (Specify)	e, rerm, s	Rreel, Tect	ory, office	1		281. LC	CATION (Street a ty or Town, State)	nd Numbe	r or Rural F	Route Number,
<u> </u>	29a. CERTIFIER			-	-	_==							
COMPLETED	(Check only 1 CERTIFYING PH	YSICIAN: To the best of INER: On the basis of a											a) and menner as stated.
Č H	296. SIGNATURE AND TITLE OF CERTIF				_		29c. LICE						(Month, Day, Year)
0	Alebon		10				03	7 6	12	_	D /	1-8	-96
유	30. NAME AND ADDRESS OF PERSON	WHO COMPLETED CAUS	SE OF DEATH (ITEM	27) (Type,	Print)	00-	o ic	Rd		rite 3	0/	Re	Stimore 21236
	31. DATE FILED (Month, Day, Year)	32 RECUETES	R'S-RIGNATURE 4	112	_ /	ere	< 11 ·	, , , , ,	180		71~	M	0 21236
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BALTIMORE,	3

DIVISION OF VITAL RECORDS, P.O. BOX 68760

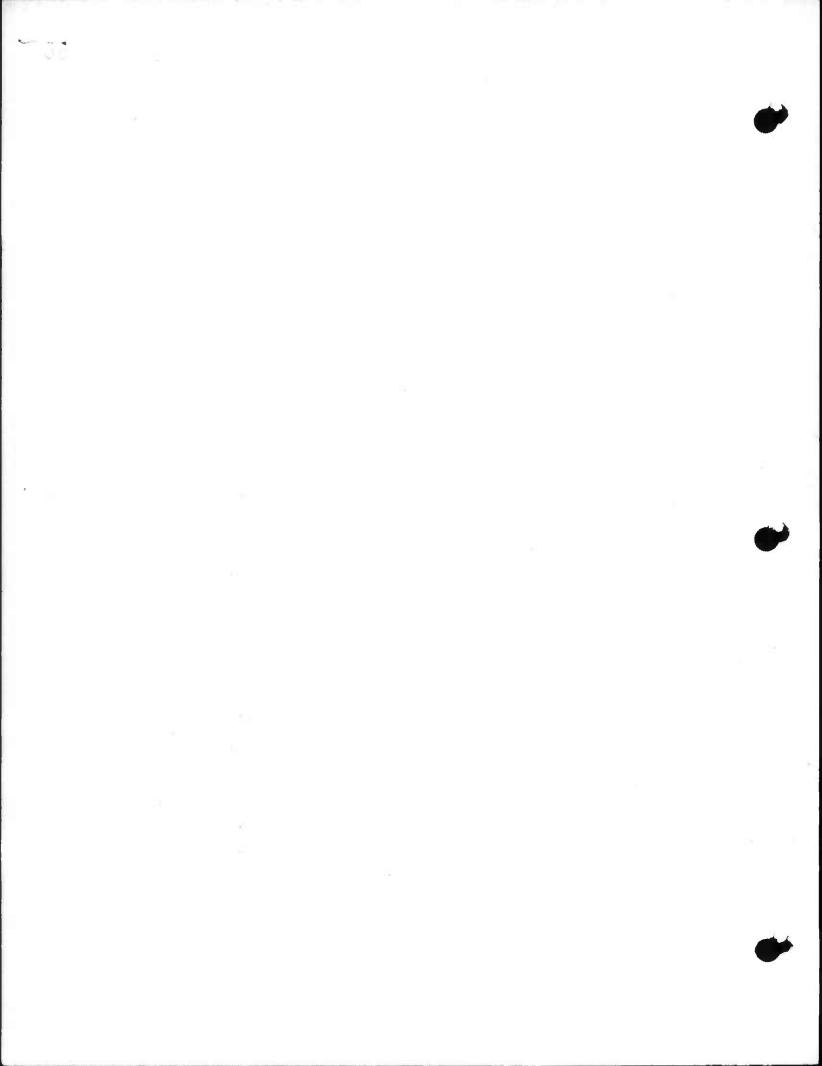
ING PHYSICIAN: The law requires that the death certificate be executed within a hours after death. Page 6 may be retained by the hospital or attending physician.	this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit nermit. Planes 1.2.3 should	th with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
law requires that the death certificate be execute	has been signed by the attending physician and c	Dept. of Health and Mental Hygiene prior to bunia	23 shows any injury, or other traumatic
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The	TO THE FUNERAL DIRECTOR: After this certificate i	be filed within 72 hours after death with the State	IMPORTANT: If Item 28 Is marked, or Item

I	tems6,7 11-9	-95 Fi	1mG729 W	.H.Per	F/H						0.6	= /	33856	
	FOR 1 STATE		STATE OF I							MENTAL HYGIEN) (
	REGISTRAR 1. OECEDENT'S NAME (First, SEDELLE I	3-5-1V: 3-1	NADDOR		CERTIF	ICATE	OF	DEA	ГН	2. DATE OF DEATH NOVEMBER		YEAR	3. TIME OF OEATN	
	4. SOCIAL SECURITY NUMB		5. SEX	8. AGE (In yrs.	last birthday)	IF UNDER	1 YEAR	IF UNDEF	24 HRS.	7 DATE OF BIRTH			0510 NPLACE (State or Fore	a _M
	285-28-0986		1 M 2 X F							APR. 15, 1931 OH				vyn
OR	98. FACILITY NAME (# not in:			CENTER		96. CITY,		OR LOCATI	ON OF DE	EATN 9c. COUNTY OF BALTIM				
EGT.	RESIDENCE OF DEC	EDENT	,		100 00	TV TOWN O	D 1 004	FIGURE						
DIRECTOR	MARYLAND	B	ALTIMORE	TIMORE HUNT VALLEY									10d. INSIDE CITY LIMITS? 1 X YES 2 N	ю
FUNERAL	100. STREET AND NUMBER		F 33703				10	f. ZIP COO			WHAT COUNTRY?			
JNE	1521 HEATHER	HILL	LANE 12. WAS DECEDEN	T EVER IN II S	ARMED	49.1	WE 0.50	210		IIC ORIGIN? (Specity Yes		USA		
ВУ	1 Never Married 2 3 Widowed 4 Divo			YES 2] 1	f yes, sp	ecity Cubi	n, Mexica	n, Puerto Rican, etc.)	e or No 14. RACE — American Indian, Black, White, etc. Specify: WHITE			•
TED		EDENT'S EDUC highest grade		16a.	DECEDENT'S	work done o	CUPATIO	ON ost of workli	ng	16b. KIND OF BU	SINESS/INC	DUSTRY		
COMPLETED	Elementary/Secondary (0	mentary/Secondary (0-12) College (1-4 or :				use retired.) USEWI	FE				OWN	HOMI	₹	
	17. FATHER'S NAME (First, Middle, Lest) 18. MOTNER'S NAME (First, Middle ANNA ANNA											STEI	GER	
TO BE	19e. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)													
F	DAVI		N/	ADDOR	1054	O BRA	NHA	M FI	ELDS	RD. DULUT	H, GA	A 30	155	
	20s. METNOD OF DISPOSITI 1 Surial 2 Crematio 4 Donation 5 Other	n 3 🗆 Remo	oval from State	20b. LA	CEAND DATE	OF OISPOS	RIAL	PARI	K 11-	-7-1995- R	CATION — ANDAI	City or To	OWN MD	
	22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & 6010 REISTERSTO								BROS., I	NC.			7.5	
	23. PART I. Enter the di	season, or o	omplications the	t caused the	death. Do	not enter	the mo	de of dy	ing, auci	h aa cardiac or reapi	retory an	reat,	Approximate	_
	iMMEDIATE CAUSE (Fin disease or condition reaulting in death)	art fallure.	a. He	ta de la composición della composición della composición della composición della composición della composición della composición della composición della composición della composición della composición della composición della composición della composición della composición della composición della composición della composición della composición della composición della com	TU.	m				Jam.			Interval Bets Onset and E	
NO	Sequentielly list condition	HILLER CONSIDER CONSCIENCE OF BANDING PORTO VESCULAR DISCOSE										SP		
CAT	cause. Enter UNDERLYING													
CERTIFICATION	CAUSE (Disease or Injur that initiated events resulting in death) LAST			(OR AS A CON	SEQUENCE O	OF):								
- 1	PART II. Other algnificat	nt condition	a contributing to	death but no	t reaulting	In the un	derlyin	g ceuse g	given in	Part I. 24s. WAS AN		24b	. WERE AUTOPSY FIND	
PHYSICIAN: MEDICAL		<u> </u>								1 TES 2		1	AMILABLE PRIOR TO COMPLETION OF CAU OF DEATH?	
M	DID TOPACCO III	SE CONITE	DIDLITE TO CA	LICE OF D	PATEL M	FC [] A	10 [1 11110					1 YES 2 1 MG	-
AN	DID TOBACCO US		CIBUTE TO CA		ACE OF DEA			JUNC	ERTAIN	1 121	_			
SIC	1 FES 2 NO		HOSPITAL:	ER/Outpatient	3 DOA	OTHER 4 Nurs		6 5 Re	sidence	6 Other (Specify)				
BY PH		Pending nvestigation	28e. DATE OF (Month, D		28b. Tik	ME OF JURY M		URY AT PRK? YES 2] NO	28d. DESCRIBE HOW I	NJURY OC	CURED		
8	3 Suicide a C	Could not be letermined	28e. PLACE O building,	F INJURY — At atc. (Specify)	home, farm,	street, fecto	ory, offic	•		281, LOCATION (Street e City or Town, State)	and Number	or Rural F	Route Number,	
COMPLET										to the cause(e) and mar				
	29b. SIGNATURE AND TITLE			termination end/	or investigation	on, in my of	pinion, d			lime, data and place, an				ed.
TO BE	AP/11	16	10n	en	ne	lle	0	/) -	OSE NUM	1383	29d, DAT	SIGNED /	(Month Day, Year)	

PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type,

31. DATE FILED (Month, Day, Year)
NOV 09 1395

12. REGISTRAR'S SIGNAYURE



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1			CENTIFI	CALE	F DEATH	REG. NO).					
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH MONTH	DAY	YEAR 3.	TIME OF DEATH			
	VIOi A	NELS.	-			NOVEMBER	3.199		5:45 p ™			
	4. SOCIAL SECURITY NUMBER 216-82-0606	5. SEX 6. AGE (In yrs.		IF UNDER 1 YEAR		7. DATE OF BIRTH JULY 4,	1012	8. BIRTHPLA Country)	NCE (State or Foreign			
			OZ YRS.				1913					
r	9a. FACILITY NAME (If not institution, give s				N OR LOCATION OF D			TY OF DEATH				
ב	MARYLAND GENERAL	RUSPITAL		DALI.	IMORE CIT	Υ	BA.		RE CITY			
DIREC	10a. STATE 10b. COUNTY	,		100	d. INSIDE CITY							
. 1	Maryland			Baltim	iore		1 [YES 2 NO				
LONERAL	100. STREET AND NUMBER 501 W. Franklin S.	de to a a de			101. ZIP CODE	10g. CITIZEN OF			COUNTRY?			
<u>i</u>		12. WAS DECEDENT EVER IN U.S.			21201		U.S.A.					
	11. MARITAL STATUS 1 Never Married 2 Married	ARMED NO			NIC ORIGIN? (Specify Youn, Puerto Rican, etc.)	C ORIGIN? (Specify Yea or No — 14. RACE - Black,						
	3 Widowed 4 Divorced		1 D Y	ES 2 NO Specifi	y:		Specify/S.	Black, White, etc. SpecinBlack				
	15. DECEDENT'S EDU							16b. KIND OF BUSINESS/INDUSTRY				
1	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind of wo	rk done during : retired.)	most of working							
	17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malden Surname)											
2	Ethel Rose	aaugneer)	19b. MAILINO A	DDRESS (Street	ot and Number or Rural	Route Number, City or To	wn, State, Zip	Code)				
	20a, METHOD OF DISPOSITION	205 81 44	CEANDDATEOR	DISPOSITION								
	t ☐ Burlel 2 ☐ Cremation 3 ☐ Remarks 4 ☐ Donation 5 [X Other (Specify) 4 1].	cemetery,	crematory or oth		Name or	OATE 20c. L	OCATION C	aty or Town,	Stata			
1	21. SIGNATURE OF PUNERAL SERVICE LIC	ENSEERonald Wade.	Dir.	22. NAME	AND ADDRESS OF FA	CILITY		0 . 4				
- 1	10001	10160		State	Anatomy	Board-655	W. Ba	ltimo	re Street			
-	Rm. B026-Baltimore, Maryland 21201-1559											
	23. PARTYL. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdisc or respiratory streat, ahock, or heert failure. List only one cause on each line. Approximate interval Between											
IMMEDIATE CAUSE (Fine)												
e. COROVARY ARTERY DISEASE SECONDARY TO 10-31-												
DUE TO (OR AS A CONSEQUENCE OF): ARTERIOSCIEROSIS VASCUAL DISEASE												
. 11		DUE TO (OR AS A CON	SEQUENCE OF):	ARTER	IOSCLEROS		DISE	ASE	Onset and Death 10-31-95			
2	Sequentially list conditions,	DUE TO (OR AS A CON	TNAL B	ARTER LEEDIN	IOSCLEROS		DISE	ASE				
5	if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A CON GASTROTOTICST	TNAL B	ARTER LEEDIN	IOSCLEROS		DISE	ASE	10-31-95			
IFICALIO	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	DUE TO (OR AS A CON GASTROTOTICST	TIVAL B SEQUENCE OF):	ARTER LEEDIN	IOSCLEROS		DISE	ASE	10-31-95			
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EDICAL	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in desth) LAST	DUE TO (OR AS A CON DUE TO (OR AS A CON DUE TO (OR AS A CON	SEQUENCE OF: SEQUENCE OF: SEQUENCE OF: Of resulting in	ARTER	IOSCLEROS G	IS VASCUAI	AUTOPSY	24b. WEI	10-31-95 10-28-95 RE AUTOPSY FINDINGS ILABLE PRIOR TO MPLETION OF CAUSE DEATH?			
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COMPLETED BY PHYSICIAN: MEDICAL	If any, leading to immediate cause. Enter UNDERLYING CAUSE. (Disease or injury that initiated events resulting in desth) LAST PART II. Other significant condition DTABITTES MICTEL DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined 29s. CERTIFIER (Check only) CERTIFYING PHYSIK	DUE TO (OR AS A CON DUE TO (OR AS A CON DUE TO (OR AS A CON DUE TO (OR AS A CON S. B CONTRIBUTE TO CAUSE OF DI CONTRIBUTE T	SEOUENCE OF): SEOUEN	ARTER LEEDING the underlying (Check only on DTHER: Nursing Ho OF 28c. If 1 set, factory, off at the time, da	IOSCIEROS G Ing ceuse given in EX UNCERTAIL e) One 5 □ Residence NJURY AT VORK? YES 2 □ NO Ifica Ite and place, and due death occured et the	Part i. 24a. WAS AI PERFO 1 YES 6 Other (Specify) 28d. DESCRIBE HOW 28f. LOCATION (Street City or Town, State to the cause(a) and mattime, data and place, a	NAUTOPSY RMED? NO INJURY OCCU and Number of	24b. WEI AMA COUD DF 1	10-31-95 10-28-95 RE AUTOPSY FINDINGS ILABLE PRIOR TO MPLETTON OF CAUSE DEATH? YES 2 NO Number;			
BE COMPLETED BY PRISICIAN: MEDICAL	If any, leading to immediate cause. Enter UNDERLYING CAUSE, Obsesse or injury that initiated events resulting in desth) LAST PART II. Other significant condition DTABETES MICTI. DID TOBACCO USE CONTE 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1X Netural 5 Pending Investigation 3 Suicide 6 Could not be determined 29a. CERTIFIER (Check only one) 29b. SIGNATURE AND TITLE OF CERTIFIER	DUE TO (OR AS A CON DUE TO (OR AS A CON DUE TO (OR AS A CON DUE TO (OR AS A CON S. B CONTRIBUTE TO CAUSE OF DI CONTRIBUTE T	SEOUENCE OF): SEOUEN	ARTER LEEDING the underlying (Check only on DTHER: Nursing Ho OF 28c. If 1 set, factory, off at the time, da	IOSCIEROS G Ing ceuse given in EX UNCERTAIL E) Ome 5	Part i. 24a. WAS AI PERFO 1 YES 6 Other (Specify) 28d. DESCRIBE HOW 28f. LOCATION (Street City or Town, State to the cause(a) and mattime, data and place, a	NAUTOPSY RMED? NO INJURY OCCU and Number of	24b. WEI AMA COULD DE 1	10-31-95 10-28-95 RE AUTOPSY FINDINGS ILABLE PRIOR TO MALETION OF CAUSE DEATH? YES 2 NO Number;			
D BY PHYSICIAN: MEDICAL	If any, leading to immediate cause. Enter UNDERLYING CAUSE, Obsesse or injury that initiated events resulting in desth) LAST PART II. Other significant condition DTABETES MICTI. DID TOBACCO USE CONTE 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1X Netural 5 Pending Investigation 3 Suicide 6 Could not be determined 29a. CERTIFIER (Check only one) 29b. SIGNATURE AND TITLE OF CERTIFIER	DUE TO (OR AS A CON DUE TO (OR AS A CON DUE TO (OR AS A CON DUE TO (OR AS A CON CON BE CONTRIBUTED TO (OR AS A CON BE CONTRIBUTED TO CAUSE OF DI 26. PI CHAPTED TO CAUSE OF DI 28. PI 28a. DATE OF INJURY (Month, Day, Year) 28a. PLACE OF INJURY — At building, etc. (Specify) CIAN: To the best of my knowledge, R: On the basis of axamination and	SEOUENCE OF): SE	ARTER LEEDING the underlying (Check only on DTHER: 10 Nosing He Nosing He Noset, factory, off at the time, de In my opinion,	IOSCIEROS G Ing ceuse given in EX UNCERTAIL e) One 5 □ Residence NJURY AT VORK? YES 2 □ NO Ifica Ite and place, and due death occured et the	Part i. 24a. WAS AI PERFO 1 YES 6 Other (Specify) 28d. DESCRIBE HOW 28f. LOCATION (Street City or Town, State to the cause(a) and mattime, data and place, a	NAUTOPSY RMED? NO INJURY OCCU and Number of	24b. WEI AMA COUD DF 1	10-31-95 10-28-95 RE AUTOPSY FINDINGS ILABLE PRIOR TO MALETION OF CAUSE DEATH? YES 2 NO Number;			

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within c_{-} hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
THE PL THE PL Shed W

	FOR STATE REGISTRAR	ATE OF MARYLAND / DE		OF HEALTH AND I	MENTAL HYGIEN						
	1. DECEDENT'S NAME (First, Middle, Lest) Mabel C. Neubauer		IN IVALE	OF DEATH	2. DATE OF DEATH DATE NOVEMBER 8,	AY YEA	3. TIME OF DEATN 1:10cm M				
	212 30 0001	M 2XXF 89 Y	YRS. MONTHS D	YEAR IF UNDER 24 HRS. DAYS HOURS MIN. OWN OR LOCATION OF DE	7. DATE OF BIRTH (Month, Day, Year) February 26,	, 1906	HATYLACE (State or Foreign Journsy) Maryland				
TOR	9a. FACILITY NAME (If not institution, give street and 1414 E. Fort Aven residence of decedent	9c. COUNTY (
L DIRECTOR	MD NO. STREET AND NUMBER	V/A	Balti	more City	у	A OFFITEN	16d. INSIDE CITY LIMITS? 10d. YES 2 NO OF WHAT COUNTRY?				
FUNERAL	1414 E. Fort Ave	AS DECEDENT EVER IN U.S. ARMED		21230	NIC ORIGIN? (Specify Yes	Unite	ed States RACE — American Indian, Black, White, atc.				
B	\$∑{Widowed 4 □ Divorced □ IF Y	PECES? 1 YES 3 NO YES, GIVE WAR OR DATES	1	YES NO Specify			Specify: White				
COMPLETED		(Give killer) (G	DENT'S USUAL OCCI and of work done duri NOT use retired.) HOMEMAK	ring most of working		Home	RY				
BE CON	17. FATHER'S NAME (First, Middle, Lest) Thomas Shanley 18. MOTHER'S NAME (First, Middle, Meiden Surname) Charlotte E. Sidley										
2	19s. INFORMANT'S NAME (Type/Print) Dolores C. Taylo		The second second	Street and Number or Rural ort Avenu							
20c. METHOD OF DISPOSITION Comment Commen											
	21. SIGNATURE OF FUNETIAL BETVICE LICENSEE	. Olo	Cha	ame and address of FA rles L. Ste D1 E. Fort	evens Funer		ne, Inc. e MD 21230				
	23. PART I. Enter the diseases, or compile shock, or heart failure. List on IMMEDIATE CAUSE (Final	nly one cause on each line.					Approximate Interval Batween Onset and Death				
	disease or condition resulting in death) a. 1+	DUE TO (OR AS A CONSEQUE	NCE OF:	the Constitution	naiur Di	rase	25 45				
CATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	DUE TO (OR AS A CONSEQUE	NCE OF):								
CERTIFICATION	that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEQUE	NCE OF):								
PHYSICIAN: MEDICAL (PART II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I 24s WSS AN AUTOPSY 24b WFF										
SICIAN		SPITAL:	DOA 4 Nursin	26. PLACE OF DEATH (CI							
ВУ РНУ	Natural 5 Pending	(Month, Day, Year)	INJURY M	28c. INJURY AT WORK? 1 YES 2 NO	28d. DESCRIBE NOW						
	3 Suicide 6 Could not be 4 Nomicide determined	28e. PLACE OF INJURY — At home, building, etc. (Specify)	form, street, factor	ry, office	281. LOCATION (Street City or Town, State		Rural Route Number,				
COMPLETED	anal and	To the best of my knowledge, death the basis of examination and/or inve					ause(e) and manner se stated.				
TO BE C	29b. SIGNATURE AND TITLE OF CERTIFIER ROTALL DOLL AT 30. NAME AND ADDRESS OF PERSON WHO COM	UMBER (QO	1 .	igned (Month, Day, Year) ember 9, 1985							

25. WAS CASE REFER	RED TO MEDICAL		26. PLACE OF DEATH (Check only one)								
EXAMINER? 1 ☐ YES 3√CX	NO	HOSPITAL: 1 Inpatient 2 ER/Outpatien	8 3 🗆 DOA	8 Other (Specify)							
27. MANNER OF DEAT	7H 5 Pending Investigation	28a. DATE OF INJURY (Month, Day, Year)	26b. TIME OF INJURY		28c. INJURY AT WORK? 1 YES 2 NO	28d. DESCRIBE NOW INJURY OCCURED					
3 Suicide 4 Nomicide	6 Could not be determined	28e. PLACE OF INJURY — A building, etc. (Specify)	t home, ferm,	28f. LOCATION (Street and Number or Rural Route Number City or Town, State)							

	Roh	SUS	-	tusk		H.	V	i. N	>				
0.	NAME AND	ADDRESS	OF	PERSON W	НО	COMPLI	ETED	CAUSE	OF	DEATH	(ITEM	27) (Type	, Print)

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO BE COMPLETED BY FUNERA	TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION
il examiner must be notified at once.	IMPORTANT: Il item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
the funeral director, page 5 should be detached for use as the burlal-transit per val.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlai-transit per be filled within 72 hours after death with the State Dept, or Health and Mental Hygiene prior to burial, cremation, or removal.
er death. Page 6 may be retained by the hospital or attending physician.	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within rouns after death. Page 6 may be retained by the hospital or attending physician.
BALLIMORE, MARYLAND 21215-0020	Division of VI At he Conds, F.O. Box 68760

mit. Pages 1, 2, 3 should

	1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.										
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE O	F DEATH			3. TIME OF DEATH	
1	Doris	Margaret Otto N				MONTH	OV. 07 1995 3,50 AM				
- 3	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (In yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7 0475 0				PLACE (State or Foreign	
	218-26-2390 9a. FACILITY NAME (If not institution, give:	1 M 2 X F 75	YRS.		OR LOCATION OF D		22, 19	9c, COUNT	Mar	yland	
DIRECTOR	Bel Air Convales	Bel Ai	ir Harford County					County			
E I					TOWN OR LOCATION			10d, INSIDE CITY LIMITS?			
	Maryland Harfo	ord County	Bel	Air						t ☐ YES 2 ☑ NO	
FUNERAL	10e. STREET AND NUMBER	101. ZIP CODE				10g. CITIZEN OF WHAT COUNTRY?					
剪	410 East MacPhai	L Road			21014			U.S.	Α.		
5	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT EVER IF FORCES? 1 YES		13. WAS DEC	ENDENT OF HISPA	NIC ORIGIN?	(Specify Yes	or No- 1	4. RACE Black,	- American Indian, White, etc.	
BY	3 X Widowed 4 Divorced IF YES, GIVE WAR OR DATES			1 TES 2 NO Specify:			,,	Whi'te			
	15. DECEDENT'S EDU	ICATION	16a. DECEDENT'S	USUAL OCCUPATION	ON	16h 1	IND OF BUS	SINESS/INDU			
E	(Specify only highest grade Elementary/Secondary (0-12)	Coffege (1-4 or 5+)	(Give kind of w life. Do NOT use	ork done during mo retired.)	st of working	1555. 1	07 500	J	o i ni		
P.	6th Grade		Homemak	er			wn Ho	ome			
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA						
BE (Albert Joseph Mai	rtin Meinl			Mildred	NMN H	larris	5			
2	19a. INFORMANT'S NAME (Type/Print)				and Number or Rural						
-	Betty Mildred Buc	kless	304 Be	lmont Co	ourt, Bei	l Air,	Mary	land	210.	L4	
	20a, METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Ram	oval from State cen	PLACE AND DATE O	F DISPOSITION /No	me of 11/9	95DATE	20c. LO	CATION CH			
	4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LII		rdens of		enetery] Ba]	.timor	e, l	Maryland	
!	21. SIGNATURE OF PONEHAL SERVICE LI	ENSEE	,		and address of facility C. Miller, Inc.						
	Bathlein	M. Mun	her	6415 I	Belair Ro	oad, E	altin	ore,	Mar	land 21206	
	23. PART I. Enter the diseases, or shock, pr heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in deeth)	List only one cause on a	ach ligh.		de of dying, auc	ch aa cardle	or reapl	ratory arres	st,	Approximate Interval Between Onset and Daath	
	resulting in deeth) a. Depsis Due to (or as a consequence of):										
NO	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury CAUSE (Disease or injury).										
ATI	Sequentially list conditions, but to conditions, but to (on as a consequence of): If any, leading to immediate cause. Enter UNDERLYING Open to (on as a consequence of):										
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease Dr Injury that initieted events resulting in deeth) LAST b. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):										Omorra	
	DART II. Other classificant and date:		a se alfolie un su						_		
AL.	PART II. Other aignificent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24s. WAS AN PERFOR						RMED? AWA!		WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO		
ă	Severe Rheumutoid arthritis								COMPLETION OF CAUSE OF DEATH?		
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN DESCRIPTION OF DEATH (Check only one) EXAMINER? 1 YES 2 NO 1 Input lant 2 EN/Outpat lant 3 DOA 4 Nursing Home 5 Residence 8 Ot 28. DATE OF INJURY 28. INJURY AT WORK?							,			1 YES 2 NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN											
S	EXAMINER?	HOSPITAL:	28. PLACE OF DEAT	OTHER:							
¥	1 YES 2 NO 27. MANNER OF DEATH	1 ☐ Inpatient 2 ☐ ER/Outp	atlant 3 L DOA 28b. TIME	~	e 5 🗆 Rasidenca			NJURY OCCU	DED		
	1 Natural 5 Pending	(Month, Day, Year)	INJU	JRY WO	RK?	200. DESC	NIBE NOW II	NJUNY OCCU	HEU		
B	• - •	28e PLACE OF IN HIRV. At home form street for							and Number or Rural Route Number,		
4 Homicide detarmined City or Town, State)								wn, Statu)			
M				nd/or investigation, in my opinion, death occured							
	29b. SIGNATURE AND TILLE OF CERTIFIER				29c. LICENSE NUMBER D34652 MI) L AVE BEL AIR M			29d, DATE SIGNED (Month, Day, Year)			
) BE	X Amm							November 7 1997			
2	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUSE OF DE	ATH (ITEM 27) (Type,	Print)				> 404.	21. En E.	. ,,	
	SCOTT HASWE		2 NORT	4 AVE	BEL	AIR	Mo	arylon	ud	21014	
	"NOV 0 "9 1995" (1)	22. REGISTRAR'S SIGN	ATORE					,			

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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH NOVEMBER 5, 1995 EDWIN PALMER 11:20pm 8. BIRTHPLACE (State or Foreign Country) 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. 1 M 2 F 058-03-9933 86 APR. POLAND 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATN 9c. COUNTY OF DEATH DIRECTOR SINAI HOSPITAL BALTIMORE N/A 10b, COUNTY 10c. CITY, TOWN OR LOCATION 10a. STATE 10d. INSIDE CITY MARYLAND 1 YES 2 NO N/A BALTIMORE FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10a. CITIZEN OF WHAT COUNTRY? 6000 IVYDENE TERRACE 21209 USA 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Maxican, Puarto Rican, etc.)
1
YES 2
NO Specify: 12. WAS DECEDENT EVER IN U.S. ARMED 14. RACE — American Indian, Black, Whita, etc. FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 1 Never Married 2 Married Specify: BY 3 Widowed 4 Divorcad WHITE 5 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest (Give kind of work done life. Do NOT use retired.) H Elementary/Secondary (0-12) College (1-4 or 5+) COMPL 4 CHEMICAL ENGINEER FOOD 17. FATNER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname) FINKELSTEIN **ABRAM** SARAH KOWALSKY BE 19a, INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 MRS. SYLVIA PALMER 6000 IVYDENE TERRACE BALTIMORE, MD 21209 20a. METNOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State Burial 2 Cremation 3 - Ramoval from State HILLTOP SERVICE CORP. 4 Donation 5 Other (Specify) 11-7-1995 TOWSON, MD 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 200 6010 REISTERSTOWN ROAD BALTIMORE 21215 MD 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such se cardiac or respiratory street, shock, or heart fellure. List only one cause on each line. Approximate Interval Between **Onset and Death IMMEDIATE CAUSE (Final** disease or condition_ MYOCARDIAL INFARCTION resulting in death) DUE TO (OR AS A CONSEQUENCE OF): CORONARY ARTERY DISEASE 5 MONTHS CERTIFICATION Sequentially list conditione, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING AORTIC STENOSIS
DUE TO (OR AS A CONSEQUENCE OF): CAUSE (Disease or injury that initiated events resulting in death) LAST ACUTE PULMONARY EDEMA PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part 1. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL PERFORMED? AVAILABLE PRIOR TO DEMENTIA, ANEMIA COMPLETION OF CAUSE YES 2 NO 1X YES 2 NO HEAD ONLY DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES INO INCERTAIN I PHYSICIAN: 26. PLACE OF DEATN (Check only one) 25. WAS CASE REFERRED TO MEDICAL OTHER:
4 | Nursing Home 5 | Residence 8 | Other (Specify) HOSPITAL: 1X Inpatiant 2 - ER/Outpatient 3 - DOA 1 TYES 2 NO 27. MANNER OF DEATN 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Netural
2 Accident 5 Pending 1 YES 2 NO В Investigation 28a. PLACE OF INJURY -- At home, farm, atreet, tactory, offica 281, LOCATION (Street and Number or Rural Route Number City or Town, State) 3 Suicide 8 Could not be determined COMPLETED 4 Nomicide 29s. CERTIFIER (Check only Check only 1 X CERTIFYING PNYSICIAN: To the best of my knowledge, dasth occurred at the time, data and place, and due to the cause(s) and manner as steted. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as attend. 29b. SIGNATURE AND TITLE OF CERTIFIED 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 8 unbor, 19 AS2402321JD9777 NOV. 5, 1995 9 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print)

JEFFREY DUNBAR SINAI HOSPITAL OF BALTIMORE 32 HEGISTRAR'S CHATURE

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BALTIMORE, MARYLAND 21215-0020

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	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH MONTH D	AY YEA	3. TIME OF DEATH	
- 1	MARY	MAGDALENE	IEBE		November 8	3, 1995	10:15 P.		
	4. SOCIAL SECURITY NUMBER 214-20-3829	1 🗆 M 2 💢 F	83 YRS.	MONTHS DAYS	HOURS MIN.		912	RTHPLACE (State or Foreign buntry) Ohio	
5	90. FACILITY NAME (II not institution, given Brightwood	street end number)			OR LOCATION OF DEA OKLANDVIL		9c. COUNTY O	Itimore	
3	RESIDENCE OF DECEDENT 10a. STATE 10b. COUN	TY	10c. CITY	, TOWN OR LOCAT				10d. INSIDE CITY	
DIRECTOR	Maryland N	I/A		altimore				LIMITS?	
FUNERAL	10e. STREET AND NUMBER			101	. ZIP CODE			OF WHAT COUNTRY?	
NE	5408 Lothian F	Oad 12. WAS DECEDENT EVER IN U	e abuen	42 UMC 050	2121	2 C ORIGIN? (Specify Yes		S.A.	
5	1 Never Merried 2 Merried 3 Wildowed 4 Divorced	FORCES? 1 YES	2 NO	If yes, sp	ecity Cuban, Mexicen, 2 X NO Specity:			ACE — American Indian, Black, White, etc. Specify: White	
	15. DECEDENT'S ED (Specify only highest gra	UCATION 19 de completed)	(Give kind of v	USUAL OCCUPATIO	ON ost of working	16b. KIND OF BU	SINESS/INDUSTF	Y	
PLET	Elementery/Secondary (0-12) 12 years	College (1-4 or 5+)	Homes	naker		Ovan	Home.		
COMPL	17. FATHER'S NAME (First, Middle, Last)		Homel	MARCL	18. MOTHER'S NAM	E (First, Middle, Maiden			
	John	Gutlik			Josephi		Pol		
2	190. INFORMANT'S NAME (Typo/Print) E. Kenneth Prie	bo				oute Number, City or Tow			
	20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City of To								
	1 N Burial 2 Cremetion 3 Re 4 Donetion 5 Other (Specify)	movel from State	adowrid	ge Memor	rial Park	11/13 E	lkridge	, Maryland	
	21. SIGNATURE OF FUNERAL SERVICE	LICENSEE			no address of faci	efeld Hom	0		
	Leve J.	-evane		6500	York Roa	d Baltim	ore, Ma	ryland 21212	
	23. PART I. Enter the disease, o shock, or heart failure immediate CAUSE (Final disease or condition resulting in death)	. List only one cause on eac	h line.					Approximata interval Betwee Onest and Dei	
CERTIFICATION	IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Entar UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST One to CAUSE (Disease or injury that initiated events resulting in death) LAST One to CAUSE (Disease or injury that initiated events resulting in death) LAST One to CAUSE (Disease or injury that initiated events resulting in death) LAST								
MEDICAL (PART II. Other significant condition	AUTOPSY RMED? 2 §7 NO	24b. WERE AUTOPSY FINDING AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO						
1	DID TOBACCO USE CON				UNCERTAIN				
SICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPITAL: 1 Inpatient 2 ER/Output		H (Check only one) OTHER:					
PHYS	27. MANNER OF DEATH	28a. DATE OF INJURY	28b. TIM	E OF 28c. INJ	JURY AT	28d. OEŞCRIBE HOW	INJURY OCCURE	0	
BY P	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJ		YES 2 NO				
ETED	3 Suicide 6 Could not b	28e. PLACE OF INJURY — building, atc. (Specify	At home, farm, s	street, fectory, offic	:0	281. LOCATION (Street City or Town, State		iral Route Number,	
COMPLE		SICIAN: To the best of my knowled						rse(a) and manner es stated.	
BE CO	296 GRATURE AND TITLE OF CERTIF	Cevany	7		29c. LICENSE NUMI D-33400	BER	29d. DATE, SIG	Nyto (Mogth, Day, Year)	
m	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Baltimore, MD								
TO BE	_ / /					uite 1G	Baltim	ore, MD 21210	

TO THE HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 28 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

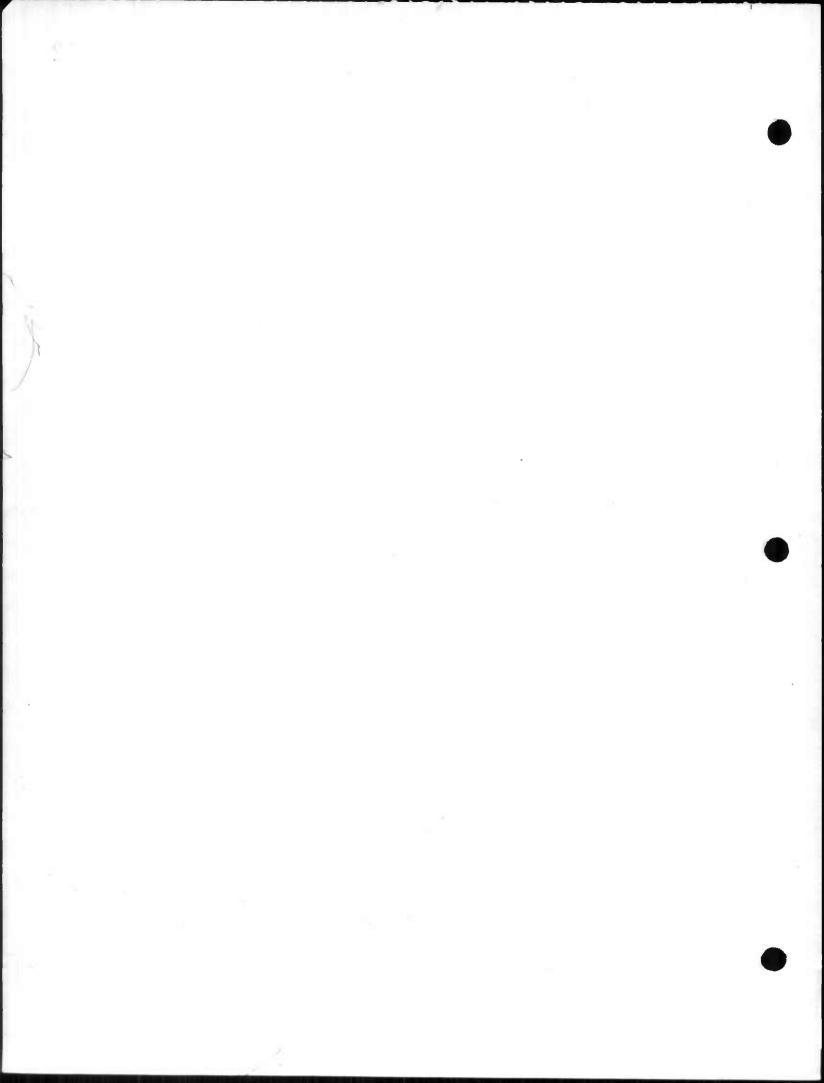
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

_	nedio Inan			7 -11111	IOAIL	. 01				ACG. NO.			
1	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH MONTH DAY YEA			YEAR	3. TIME OF DEATH			
	PAUL			POWELL			OCTOBER 26.19			1995	2255 P M		
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs.		IF UNDER	1 YEAR DAYS	IF UNDER	24 HRS.	7. DATE (OF BIRTH , Day, Year)			PLACE (State or Foreign
	11€ M 2 □ F 38 YR					June 4, 1957					"		
,	9e. FACILITY NAME (If not institution, give street end number)					TOWN	OR LOCATI	ON OF DE				NTY OF D	EATH
OR	311 CATHEDRAL STREET					BALTIMORE CITY							
5	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY	,		400 CIT	Y, TOWN O	D LOCA	TION						10d, INSIDE CITY
DIRECTOR						ore	IION						LIMITS?
AL	10e. STREET AND NUMBER					10	. ZIP COD				10g. CIT	IZEN OF W	HAT COUNTRY?
	311 Cathedral Str	eet-#B1						2120	1				
Y FUNERAL	11. MARITAL STATUS 1 Never Married 2 Merried 12. WAS DECEDENT EVER IN U.S. ARM FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES				1	If yee, sp		m, Mexico	en, Puarto P	? (Specify Yes licen, atc.)	or No-	Black	- American Indian, White, etc.
B	3 Wildowed 4 Divorced												Black
	15. DECEDENT'S EDU (Specify only highest grade			OECEDENT'S (Give kind of	work done o			ng	16b.	KIND OF BUS	SINESS/IN	DUSTRY	94.1
COMPLETED	Elementary/Secondary (0-12) College (1-4 or 5+)				se retired.)								
	17. FATHER'S NAME (First, Middle, Lest)						18. MOT	HER'S NA	ME (First, A	Aiddle, Meiden	Surname)		
8	19e. INFORMANT'S NAME (Type/Print)			19b. MAILING	G ADDRESS	3 (Street	end Numbe	r or Rural	Route Numb	per, City or Tow	n, State, Zi	p Code)	
임													
	20s. METHOD OF DISPOSITION 1			CE AND DATE		SITION (N	ame of		DATI	20c. LO	CATION —	City or To	wn, State
- 1	21. SIGNATURE CEPT TERAL SERVICE LICENSER On ald Wade, Dir. State Anatomy Board-655 W. Baltimore Street												
	Strainel /	el las	12_										more Street
	23. PART I. Enter the disesses, or												Approximate interval Between
	ahock, or heart fellure. List only one cause on asch line.								Onset and Desth				
	disease or condition a. Multiple Gun Shot Wounds Due to (OR AS A CONSEQUENCE OF):												
	DUE TO (OR AS A CONSEQUENCE OF):												
z													
CERTIFICATION	Sequentisily list conditions, If any, leading to immediata DUE TO (OR AS A CONSEQUENCE OF):								(
S	Cause. Enter UNDERLYING CAUSE (Disease or injury								ļ				
	that initiated evanta	DUE TO	(OR AS A CON	SEOUENCE (OF):								
E	resulting in death) LAST												
	PART ii. Other significant conditions contributing to death but not resulting in the underlying causa given in Part i. 24a, WAS AN AUTOPSY								246	. WERE AUTOPSY FINDINGS			
ৰ		_						PERFORMED?				AVAILABLE PRIOR TO COMPLETION OF CAUSE	
EDICAL								1 YES			S MO		OF DEATH?
Σ	DID TOBACCO USE CONT	DIBLITE TO CA	LISE OF D	EATH V	ES 🗆 I	NO F	T HNI	CEDTAL	N D				1 YES 2 NO
A	25. WAS CASE REFERRED TO MEDICAL	T		LACE OF DE				ÇEKIMI	14 🗀]				
S	EXAMINER?	HOSPITAL:	- 12-0-1		OTHE	R:			. 57.04	- 45 4 1	N.D. C	OEN	
PHYSICIAN:	27. MANNER OF DEATH	1 Inpatient 2	***************************************	Tan m		-	JURY AT	lasidence	8 X Othe	CRIBE HOW		CEN	E
	1 Natural 5 Pending	(Month, D	ay, Year)	with 14	JURY M	W	ORK7 YES 2	NO	0 1	jest	she		
BY	2 Accident Investigation	280 PLACE C	F INJURY - AI					7 110		ATION (Street			Route Number
COMPLETED	3 Suicide 8 Could not be 4 Homicide determined		atc. (Specify)	iduu						or Town, Stete.)		street.
2	29a. CERTIFIER 1 CERTIFYING PHYS	SICIAN: To the best of	my knowledge	, death occur	rred at the t	time, dat	e end plac	e, and du	e to the car	use(a) and ma	nner ee at	sted.	
W	enel	ER: On the beele of a	yamination end	or investigat	fon, In my (opinion,	death occ	ured at the	e time, date	end place, e	nd due to	the couse(e) end manner ee stated.
	29b. SIGNATURE AND TITLE OF CERTIFIE	R					29c. LIC	CENSE NU	IMBER		29d, DA	TE SIGNED	(Month, Day, Year)
BE		Ph.	_					C.M					ER 27,1995
2	30, NAME AND ADDRESS OF PERSON WI	HO COMPLETED CAU	SE OF DEATH (TEM 27) (7/2	e, Print)		<u> </u>	C . PI	• تا •		1 00	, I UD.	LI 21,1993
	DAVID R FO	wler	111	Donn	Ctr	<u>eet</u>	, Ba	alti	more	e, Ma	ryla	and	21201
	31. DATE FILED (Month, Day, Year) NOV 09 199	32. REGISTRA	R'S SIGNATUR	Pad-H									
	NOV 0.9 199	James a	A KINGKISK A	THE PARTY									



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FOR STATE REGISTRAR 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Richard Vincent Pirozzi November 6 12:15 Am 1995 7. DATE OF BIRTH (Month, Day, Year) Aug. 25,1935 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign MONTHS DAYS 1 M 2 - F Maryland 213-30-3222 use as the burial-transit permit. Pages 1, 2, 3 should Se. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Baltimore Edgemere DIRECTOR 6929 River Drive Road RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Edgemere Maryland Baltimore 1 YES 2XX NO FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 21219 United States 6929 River Drive Road 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No—If yes, specify Cuben, Mexicon, Puerto Ricen, etc.)

1 YES 2 NO Specify: 14. RACE — American Indien, Black White etc. FORCES? 1 YES 2X NO 1 Never Married 2 Merried Specify: White ВУ 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 180. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only higher (Give kind of work done life. Do NOT use retired.) College (1-4 or 5+) page 5 should be detached for Elementery/Secondery (0-12) G.E.D. Welder Steel Industry 17. FATNER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Sumeme) Madelyn Ingle Ħ Ralph Pirozzi notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 6929 River Drive Road Edgemere, MD 21219 Gertrude A. Pirozzi be 20 METHOD OF DISPOSITION

12 Burlet 2 Cremetion 3 Removal from State

13 Denution 5 Cher (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE must filled in by the funeral director, Parkwood Cemetery 11/10/95 Parkville, Maryland RAL SERVICE LICENSEE examiner 22. NAME AND ADDRESS OF FACILITY Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, MD 21222 medical complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and, List only one cause on each line. 23. PART I. Enter the diseases. shock, or heart to interval Between IMMEDIATE CAUSE (Finel DUE TO (OR AS A CONSEQUENCE OF): the disease or condition and completely fi o bunial, cremation reaulting in death) traumatic event, . un Travalin Dependent Drunetes mellitus CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF): prior to if any, leading to immediate the attending physician Mental Hygiene prior to Hypertension cause. Enter UNDERLYING CAUSE (Disease or injury or other DUE TO (OR AS A CONSEQUENCE OF) thet initiated eventa resulting in death) LAST PART il. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? PHYSICIAN: MEDICAL 24b. WERE AUTOPSY FINDINGS has been signed by Dept. of Health and **AMILABLE PRIOR TO** shows any COMPLETION OF CAUSE 1 0 YES 2 | NO OF DEATH? 1 X YES 2 | NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN D 23 28. PLACE OF DEATN (Check only one) 25. WAS CASE REFERRED TO MEDICAL this certificate h EXAMINER? HOSPITAL: OTHER:
4 | Nursing Home | 5 | Residence | 6 | Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 0 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE NOW INJURY OCCURED marked, 1 X Natural 5 Pending 1 YES 2 NO BY DIRECTOR: After the hours after death vitem 28 is mark Investigation 2 Accident 3 Suicide 28e. PLACE OF INJURY — At home, ferm, street, fectory, office building, etc. (Specify) 281, LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined COMPLETED 4 Homicide 29e. CERTIFIER

(Chack only)

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end menner ee stated. FUNERAL I within 72 h 2 MEDICAL EXAMINER: On the beste of exemination end/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(e) and manner se attend. IMPORTANT: 29b_SIGNATURE AND TITLE OF CERTIFIER 29c LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) THE 8 Riberte Druf de D39660 945 MD 12 2 2 3 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Bultimore unD Robert C. Durt 10 707 E. Fort 21230 32 REGISTRAR'S BNATURE 31. NOV 0 9 1995

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

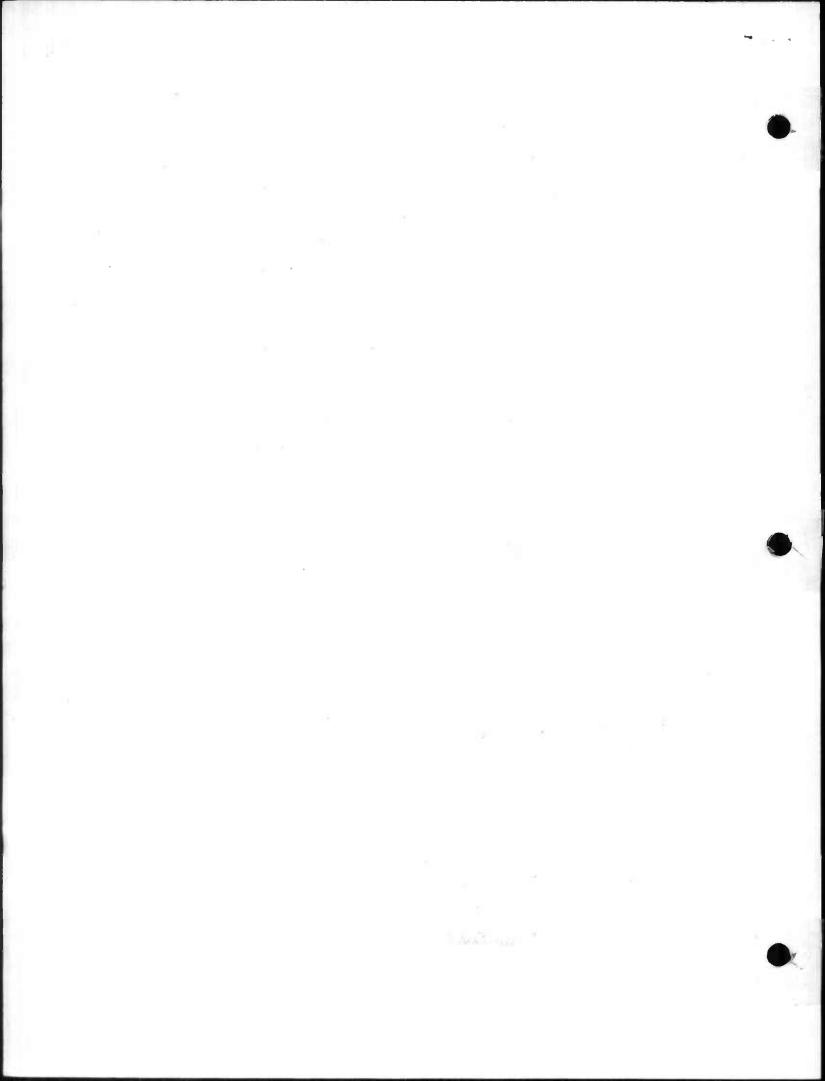
REG. NO.

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		4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. I		IF UNDE		IF UNDER	R 24 HRS.	7. DATE O	F BIRTH		. BIRTHE	PLACE (State or Foreign
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1, 2, 3	DIRECTOR	3708 Crestfi	eld Cour	rt		BAUTMORE						N	A	
	REC	10e. STATE 10b. COU	NA		100-01	ry, TOWN			3					10d. INSIDE CITY LIMITS?
mit. P		10e. STREET AND NUMBER	1011		2) AC		WOK						1 VES 2 NO
sit per	RA	100. STREET AND NUMBER 3708 CLEST FLELD COURT 109. CITIZEN OF WHAT LISA									L COUNTRY?			
burial-transit permit. Pages	FUNERAL	11. MARITAL STATUS	12 WAS DECEDED	AT EVED IN II C	ABMED			CENDENT (OF NISPA	NIC ORIGIN?		or No—	4. RACE	- American Indian,
as the buri	В	1 Never Merried 2 Merried 3 Widowed 4 Divorced	IF YES, GIVE	YES 2	Zho			2 XNO		en, Puerto Ri fy:	cen, etc.)		Specify	Black
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5 should be detached notified at once.	BE CO	17. FATNER'S NAME (First, Middle, Last) CECIL L	ROBER	75				18. MOT	HER'S NA	AME (First, MI	. 0	Sumame))	
e 5 should notified	10	190. INFORMANT'S NAME (Type/Print) 190. MAILING ADDRESS (Street and Number or Flural Poute Number, City or Fown, State, Zip Code) 190. MAILING ADDRESS (Street and Number or Flural Poute Number, City or Fown, State, Zip Code) 190. MAILING ADDRESS (Street and Number or Flural Poute Number, City or Fown, State, Zip Code) 190. MAILING ADDRESS (Street and Number or Flural Poute Number, City or Fown, State, Zip Code)												
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P o E											Interval Between Onset and Desi			
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ned by the a th and Ment any injury	MEDICAL C	PART II. Other significant condition	iona contributing to	daath but not	t reaulting	In tha u	nderlyin	g cause	given in		24a. WAS AN PERFOR	MED?	24b.	WERE AUTOPSY FINDING AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
sen signed of Health a shows and	ME	1 VES 2 NO												
Dept. of 23 she	AN	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 125. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one)												
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th the	숲	27, MANNER OF DEATH	28e. OATE O	F INJURY	28b. TII	WE OF	28c. IN.	JURY AT	esidence	_		NJURY OCCI	JREO	
After this death with s marked,	ВУ Р	Natural 5 Pending Accident Investigatio		Day, Year)		JURY M		YES 2 [□ NO					
after d	ETED (3 Suicide 8 Could not I 4 Nomicide determined	pq building	OF INJURY — At I	home, farm,	street, fed	tory, offic	ce			TION (Street of Town, Stete)	and Number o	r Rural R	oute Number,
7 N +	COMPLE	one)	YSICIAN: To the best of											end manner es stated.
TO THE FUNERAL IS TO THE WITHIN 72 H	O BE C	296. SIGNATURE AND TITLE OF CERTIFIER						.02	ENSE NU	83		29d. DATE	SIGNED	(Month, Day, Year)
	ĭ	30. NAME AND ADDRESS OF PERSON	MN.D., Z	SE OF OEATH (IT	150 V	ede v	re A	ne	BR	ltv,	m	212	-15	
		31. DATE FILEO (Month, Day, Year) NOV 0 91995	32. REGISTR	ADS SIGNATURE							-			
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.



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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within X hours after death. Page 6 may be retained by the hospital or at	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use the material of the funeral director, page 5 should be detached for use the material director, page 5 should be detached for use	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	REGISTRAR	CERTIFIC	CATE OF I	DEATH	R	EG. NO.					
	DECEDENT'S NAME (First, Middle, Last) Harry Raymo	ond Rollin	s		2. DATE OF E	DAY	YEAR	3. TIME OF DEATH 5:05 α. M			
	6.		F UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF B	IRTH	a. BIRTH	PLACE (State or Foreign Vict of Col.			
	215-52-6263 9e. FACILITY NAME (If not institution, give street end number)		b. CITY, TOWN OR	LOCATION OF DEA		-	UNTY OF D				
TOR	5102 Manning Drive		Bethe			1000	ontgo				
EC	100. STATE 10b. COUNTY	10c. CITY,	TOWN OR LOCATIO	ON				10d. INSIDE CITY LIMITS?			
L DIF	Maryland Montgomery 100. STREET AND NUMBER	Bet	hesda	ZIP CODE		10- 0	TITEN OF N	1 YES 2 NO			
FUNERAL DIRECTOR	5102 Manning Drive		101.	20815			.S.A.				
ВУ	11. MARITAL STATUS 1 X Never Married 2 Merried 3 Wildowed 4 Divorced 12. WAS OECEDENT EVER FORCES? 1 YES IF YES, GIVE WAR OR (2 X NO	It yes, spec	NDENT OF HISPANI Sify Cubert, Mexicer 2 X NO Specify.	n, Puerto Ricar		14. RACI Blac Spec	E — American Indian, k, White, ptc. ny White			
ED	15. OECEDENT'S EDUCATION (Specify only highest grade completed)	16a. DECEDENT'S US	BUAL OCCUPATION			D OF BUSINESS/II					
COMPLETED	Elementary/Secondary (0-12) College (1-4 or 5+)	Administ	retired.)	or working	Cent	ral Int	ellig	ence			
OM	17. FATHER'S NAME (First, Middle, Last)			18, MOTHER'S NAM							
BE C	Harry R. Rollins			Jenny A	nderse	.n					
TO B	190. INFORMANT'S NAME (Type/Print) (friend)			d Number or Rural R							
F	Kevin T. Healey	5102 Ma	nning D	rive-Bet	hesda,	Maryla	nd	20815			
	20e. METHOD OF DISPOSITION 1 □ Burlel 2 □ Cremetion 3 □ RemoveLfrom State 4 □ Donation 5 ♥ Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of cametery, crematory or other place) 20c. LOCATION — City or Town, State										
	11. HOLLANDIE OF FURNISH SERVICE LICENSEE RONALD WO	ade, Dir.	State 1	Anatomy	Board-	655 W.	Balti	more Street			
- /	Towns I clade		Rm. B02	6-Baltim	ore, N	laryland	212	01-1559			
	shock, or heart failure. List only one cause on each lina. IMMEDIATE CAUSE (Final disease or condition reaulting in death) BABLE NONHOD 6KIN'S LYMPHOMA / month										
CERTIFICATION	Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Diseese or Injury that initiated events resulting in death) LAST										
S	d										
MEDICAL	PART II. Other algorificant conditions contributing to death	but not resulting in	the underlying	cause given in		PERFORMED? YES 2 X NO	Y 241	b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO			
	DID TOBACCO USE CONTRIBUTE TO CAUSE	OF DEATH YES	□ NO ☑	UNCERTAIN	1 D						
NA.	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH									
SIC	1 YES 2 XNO HOSPITAL: 1 Inputient 2 ER/Ou	tpstlent 3 DOA	OTHER: Numing Home	5 X Residence	8 Other (Sp	pecify)					
Y PHYSICIAN:	27. MANNER OF DEATH 1 X Natural 5 Pending Investigation	28b. TIME INJUI	RY WOF	PRY AT RK? ES 2 NO	28d. DESCR!	BE HOW INJURY (CCUREO				
TED BY	Z PECTORITE	RY — At home, term, streedily)	met, factory, office			LOCATION (Street and Number or Rural Route Number, City or Town, Stete)					
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TO BE	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF E	DEATH (ITEM 27) (Type, F	Print)	29c. LICENSE NUN	MBER	. 1070		0 (Month, Day, Year) BER 12, 1995			
	Carolyn B. Hendricks, M.D. 1	0605 Conco	ord Stre	et, Kens	sington	1, MD. 2	0895				
	31. DATE FILEO (Month, Day, Year) 32. REGISTRAR'S SIG										
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S2 REGISTRATES SIGNATURE

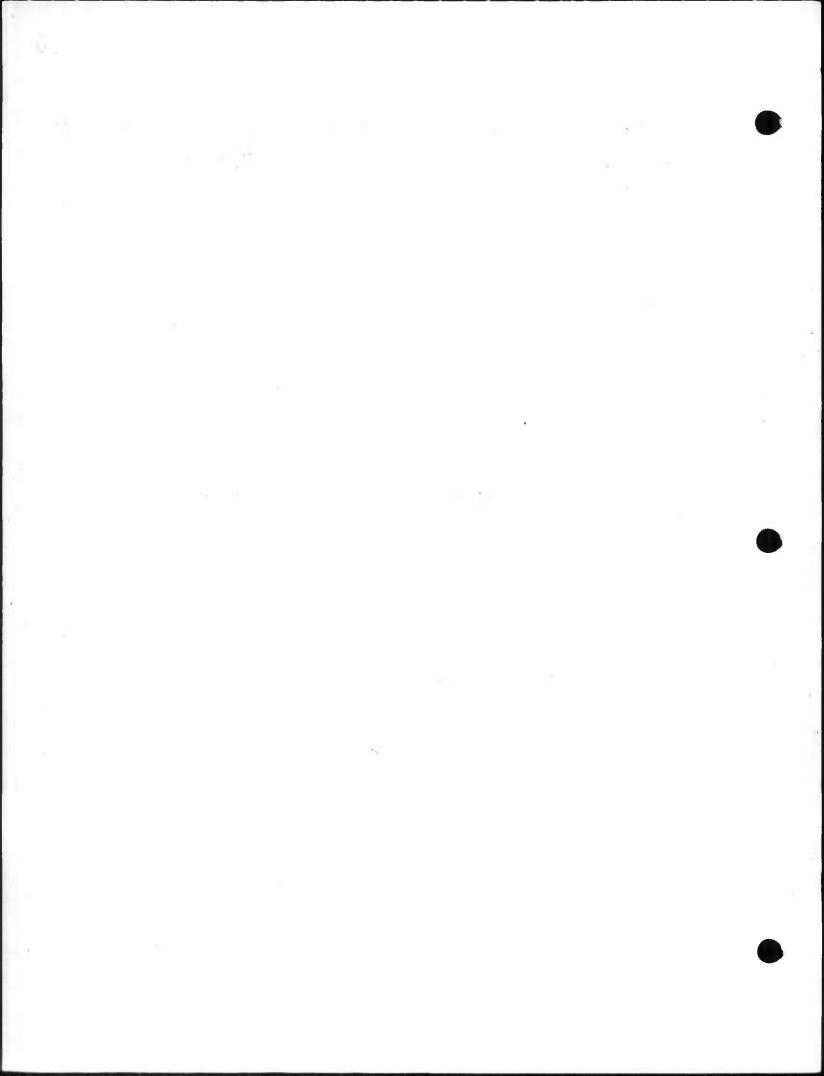
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

VASANT DATTA, MO

	REGISTRAR 1. DECEDENT'S NAME (First, Middle, Last Pauline	Scott	"White	D	F DEATH	2. DATE OF DEATH MONTH	~ 3 199	3. TIME OF DEATH				
Œ	4. SOCIAL SECURITY NUMBER 065-05-6432	5. SEX 8. AGE (1)	in yrs. last birthday) YRS.	IF UNDER 1 YEAR			0.0	IRTHPLACE (State or Foreign ountry) SSOUTÉ				
TOR 1	90. FACILITY NAME (IT not institution, give Fahrney Keedy Nu RESIDENCE OF DECEDENT				n or location of Sboro	DEATH	9c. COUNTY (engton				
DIRECTOR	ton. STATE tob. COUR	ington		v, town on Lo				10d. INSIDE CITY LIMITS? 1 YES 2 NO				
FUNERAL	100. STREET AND NUMBER 8507 Mapleville	Road			21713		10g. CITIZEN	of what country?				
₽	11. MARITAL STATUS t Never Merried 2 Merried 3 X Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 _ YES IF YES, GIVE WAR OR DA	2 X NO	If yes,		PANIC ORIGIN? (Specify Yolcan, Puerlo Ricen, etc.) cify:		RACE — American Indian, Black, White, ejc. Specify: White				
PLETED	15. DECEDENT'S EI (Specify only highest gra Elementary/Secondary (0-12)		16a. DECEDENT'S (Give kind of life. Do NOT us Manage	work done during se retired.)	ATION most of working	16b. KIND OF BU	JSINESS/INDUSTI	RA				
ed at once. BE COMPL	17. FATHER'S NAME (First, Middle, Last) John Morgan Whit	e			18. MOTHER'S	NAME (First, Middle, Maide L Boyd	n Surneme)					
5	190. INFORMANT'S NAME (Type/Print) Brad and Nancy B	rowning				ni Route Number, City or To NUC-Hagers		eryland 21742				
r must be	20e. METHOD OF DISPOSITION 1	emoval from Stata cem	PLACEAND DATE etery, crematory or o	ther place)			OCATION — City					
al examiner	21. SIGNATURE OF FUNERAL SERVICE	State Anatomy Board-655 W. Baltimore Street Rm. B026-Baltimore, Maryland 21201-1559										
event, the medical	23. PART I. Enter the diseases, o shock, or heart failur shock and the s	r complications thet ceused a. List only ona causa on a	I tha death. Do a sch line.		mode of dying, s	uch as cardiec or res	piratory arrest,	Approximata interval Between Onset and Death				
44 - 1	Sequantially list conditions, if sny, leading to immediate cause. Enter UNDERLYING	b	CONSEQUENCE O	prelife	ectu 1	Dirady		ns				
CERTIFICATION	CAUSE (Disesse or injury that initiated evants resulting in death) LAST	d	CONSEQUENCE O	F):								
amy inju	PART II. Other significant condition with med	tites cire			ing cause givan	DEDEC	PRMED?	24b, WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?				
SICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL EXAMINER?			26.	PLACE OF DEATH (Check only one)		1 YES 2 NO				
ō ≥	1 YES 2 NO	HOSPITAL: 1 Inpatient 2 ER/Outp 26e. DATE OF INJURY	atlent 3 DOA	-		e 8 Other (Specify)	INJURY OCCURE	0				
	1 Ratural 5 Pending 2 Accident Investigation	26s. PLACE OF INJURY	JURY WORK? M 1 YES 2 NO									
8 is marker ED BY P	3 Suicide 8 Could not b											
D BY P	4 Homicide determined 29e. CERTIFIER (Check only 1 CERTIFYING PHY	/SICIAN: To the best of my knowl						JSe(e) and manner on stated				

334 MILL ST

MAREKSTOWN, NO ZITYO



THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burital, cremation, or removal.	PORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HC	TO THE FU	be filed wil	IMPORTA

	FOR STATE REGISTRAR	STATE OF MARYLAND	/ DEPARTME	NT OF H	EALTH AND I		YGIENE EG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last) GEORGE W 4. SOCIAL SECURITY NUMBER 215-07-11129	11 iam R 5. SEX 8. AGE (In yrs. A	LUND,	JR HOER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	2. DATE OF D MONTH 7. DATE OF B (Month, Day	DEATH DAY 03	Countr			
DIRECTOR	9e. FACILITY NAME (If not institution, give st GOOD SAMALITAN. RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY	treet and number) Hospital		Ва		eath City		3 Mar			
FUNERAL DII	Maryland 100. STREET AND NUMBER 5516 Mayview A				ZIP CODE	ltimore 1206	109.	nited	XXX YES 2 1 NO WHAT COUNTRY? States		
B	tt. MARITAL STATUS t Never Married 2 Married 3 Widowed 4 Divorced		ECEDENT'S USUA	If yes, sp	ENDENT OF HISPAI ocity Cuban, Maxica 2 NO Specifi	in, Puerto Rican y:		Speci	E — American Indian, t, White, atc.		
COMPLETED	(Specify only highest grade Elementary/Secondary (0-12) 7 YPATA 17. FATHER'S NAME (First, Middle, Lest)	College (1-4 or 5+)	(Give kind of work di fe. Do NOT use retin Forema	ed.)		ME (First, Middle		Compan	u		
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	IMMEDIATE CAUSE (Fine)	complications that caused the Liat only one cause on each of the complete that the cause of the	eath. Do not e	nter the mo	de of dylng, suc				Approximate Interval Between Onset and Death		
CERTIFICATION	DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): YEARS DUE TO (OR AS A CONSEQUENCE OF): On the conditions of the conditions										
MEDICAL C	t YES 2 NO OF DEATH?								AVAILABLE PRIOR TO COMPLETION OF CAUSE		
PHYSICIAN:	DID TOBACCO USE CONTI 25. WAS CASE REFERRED TO MEDICAL EXAMINER? t \(\text{YES} \) 2 \(\text{Y} NO \)		ACE OF DEATH (C)	eck only one) HER:	UNCERTAL 6 6 Realdence		ecify)				
D BY	27. MANNER OF DEATH t Netural 5 Pending Investigation 3 Suicide 6 Could not be detarmined City or fown, State) 28s. DATE OF INJURY 28b. TIME OF INJURY AT WORK? M t YES 2 NO 28s. INJURY AT WORK? t YES 2 NO 26s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						N (Street and Nu	JURY OCCURED d Number or Rural Route Number,			
COMPLETE	one) 2 MEDICAL EXAMINE	CIAN: To the best of my knowledge,			esth occured at the	time, date and	placa, and dua	to the cause(s			
TO BE	296. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WH	un M.D.	EM 27) (Type, Print)	44 16	D470	193	•	NOV	03,1995		
	31. DATE FINE TO THE POPULATION	LATICALLY 5601	LOCH R	AVEN	BLVD,	DAUTE), MO	2/2	37		

BALTIMORE, MARYLAND 21215-0020

DIRECTOR

FUNERAL

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CERTIFICATION

PHYSICIAN: MEDICAL

BY

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TO THE FUNERAL DIRECTS be filed within 72 hours at IMPORTANT: It item 2

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UN ALLENDING PRINCIPLY. He am requires that the death detailed to executed minimal called order. Tage of the respiratory attenting	DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages to how after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH NOVEMBER 7,1995 ANNE SIEGEL 7 am 7. DATE OF BIRTH (Month, Day, Year)
FEB. 8,1912 MARYLAND 4. SOCIAL SECURITY NUMBER 5 SEX 6. AGE (In yrs. last birthday) 8. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR 219-56-3978 DAYS MONTHS HOURS 1 M 2 F 83 9a. FACILITY NAME (If not institution, give street and number, 96. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF OEATH 3737 CLARKS LANE, APT. 108 BALTIMORE N/A RESIDENCE OF DECEDENT IDc. CITY, TOWN OR LOCATION 10d. INSIDE CITY N/A MARYLAND BALTIMORE 1X YES 2 NO 10e. STREET AND NUMBER 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 3737 CLARKS LANE, APT. 108 21215 USA 12. WAS DECEDENT EVER IN U.S. ARMEO FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No— It yes, specify Cuban, Maxican, Puarto Rican, atc.) 14. RACE — American Indian, Black, White, etc. It yes, specify Cube

1 YES 2 NO 1 Never Married 2 Married Specify Specify: 3 Widowed 4 Divorced WHITE 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high ive kind of work done Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) 12 HOUSEWIFE OWN HOME 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) MORRIS WEINSTEIN SARAH Borofsky 19a, INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) TAMARA S. PLANT 14 BRANCHWOOD COURT BALTIMORE, MD 21208 MRS. 20s. METHOD OF DISPOSITION
143 Buriel 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE BALTIMORE HEBREW 11-8-1995 REISTERSTOWN, MD 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. voul 00 6010 REISTERSTOWN ROAD BALTIMORE, MD 21215 23. PART I. Enter the diseases, or complications that caused the death. Oo not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fellure. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Final Onset and Death 6 bleed disease or condition_ resulting in death) DUE TO (OR AS A CONSEQUENCE OF): coagulopmy (DIU) VASCU Lar Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING UNG CANCEN CAUSE (Disease or Injury that Initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY 246. WERE AUTOPSY FINDINGS PERFORMED? AMAILABLE PRIOR TO COMPLETION OF CAUSE 1 TYES 2 NO 1 TES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 26. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL OTHER:
4 | Nursing Home | 5 | Residence | 6 | Other (Specify) HOSPITAL 1 TYES 1 | Inpatient 2 | ER/Outpatient 3 | DOA 27. MANNIER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 2 Accident 5 Pending 1 YES 2 NO 28e. PLACE OF INJURY — At home, term, streat, factory, office building, etc. (Specify) 3 🔲 Swieddie 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be 29a, CERTIFIER 1 (CERTIFYINO PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and menner as stated. 2 MEDICAL EXAMINER: On the basic of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as ateled. 29b. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Day, () Q 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) swen 32. REGISTRAR'S SIGNATURE

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1 -	FOR STATE REGIS	TRAR
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4. 8	OCIAL S	ECURIT
21	-9-2	-05
9a.	FACILITY	NAME
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10 a.	STATE	
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11, 1	MARITAL	STATU

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

1. DECEDENT'S NAME (FI								2. DATE OF		y -1 -	YEAR.	3. TIME OF DEATH	
		ry Steg						1995 4:30 A					
4. SOCIAL SECURITY NU 219-20-41		6. AGE (In yrs. In		MONTHS DAYS	HOURS	MIN.		192	6	Mar	yland		
9a. FACILITY NAME (# no			9b. CITY, TOWN	or Location	eath 9c. COUNTY OF								
4834 HOTT	4834 Hoffmanville Rd.							Carro			LOT	<u></u>	
10e. STATE	10e. STATE 10b. COUNTY 10c. (10d. INSIDE CITY LIMITS?	
	Maryland Carroll						E .					1 YES 2 NO	
	4834 Hoffmanville Rd.											S.A.	
11, MARITAL STATUS 1 Never Merried 2 3 Widowed 4 D			NT EVER IN U.S. 1 YES 2 X WAR OR DATES	MED AO	13, WAS DE If yes, 6 1 _ YE	CENDENT O	F HISPAN n, Mexica Specify					- American Indian, White, etc.	
	ECEDENT'S EDI	CATION	I 18e. D	FCFDFNT'S	USUAL OCCUPAT	ION		16b. I	CIND OF BUS	SINESS/IND	USTRY	MILLOG	
(Specify Elementary/Secondary	only highest grad	completed)	\$	Sive kind of w e. Do NOT use	vork done during n	nost of working	ng					IN	
6	(0-12)	Contract (1-4 of 5	,	Truc	ck Dri	ver		ı	in F	late	Pr	oducts	
Elementary/Secondary 17. FATHER'S NAME (First Edward decomposition of the control of the contr		les Hen	ry Ste	ger	41			R. T				716.	
194, INFORMANT'S NAME Ada Virgi	, ,,	teger			AOORESS (Street							21107	
20erMETHOD OF DISPOS 1 A Burlel 2 Creme 4 Donallon 8 Ott	ition 3 🗆 Ren	noval from State	20b.PLACE Cemetery. Co	AND DATE OF AMERICAN COLUMN	of disposition (interplace)	em.	11-	13-9		anche		er, Md.	
21. SIGNATURE OF FUNE	RAL SERVICE L	CENSEE 5	14		Eckh 3296	and addre	ss of fa	neral l Dr.	L Cha	pel			
Sequentially list con if any, leading to lim cause. Enter UNDER CAUSE (Disease or I that initiated events resulting in death) L	ditiona, nediate LYING njury	c	O (OR AS A CONSI	EOUENCE OF	F):	UMA	C	Spi	nt	Rec	tun	Onset and Daath	
	PART II. Other algnificent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24s. WAS AN AUTO PERFORMED? 1 YES 2									RMED?	SY 24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO		
	USE CON	TRIBUTE TO C	AUSE OF DE	ATH YE	S NO	□ UNC	ERTAI	N 🗆					
DID TOBACCO 25. WAS CASE REFERRE EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH	TO MEDICAL	HOSPITAL:	26. PL	CE OF DEAT	TH (Check only on OTHER:	0)	,						
1 TES 2 NO		1 Inpatient 2	☐ ER/Outpatient	-	4 - Nursing He		eeldence						
27. MANNER OF DEATH 1 Natural 5 2 Accident	Pending Investigation	1	Day, Year)	28b. TIM	JURY \	NJURY AT WORK? YES 2 [ND ND	28d. DE\$0	CRIBE HOW	INJURY OC	CUREO		
	Could not be determined	28e. PLACE building	OF INJURY — At I g, etc. (Specify)	nome, farm, s	street, factory, of	fice			TION (Street r Town, State)		or Rural I	Route Number,	
opei		SICIAN: To the best										s) and manner as stated.	
296. SIGNATURE AND SI	1+7	1 our	1 Mu	0		D		138	_	> 1	1/9	(Month, Day, Year)	
Wil	7	ord /	USE OF DEATH (IT	322 322	3 MA	INS	st.	MI	ANC	hes	ter	11/21/02	
31, DATE FILED (Month, C	0 9199	5 Julia	de signature	Cardoll									

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

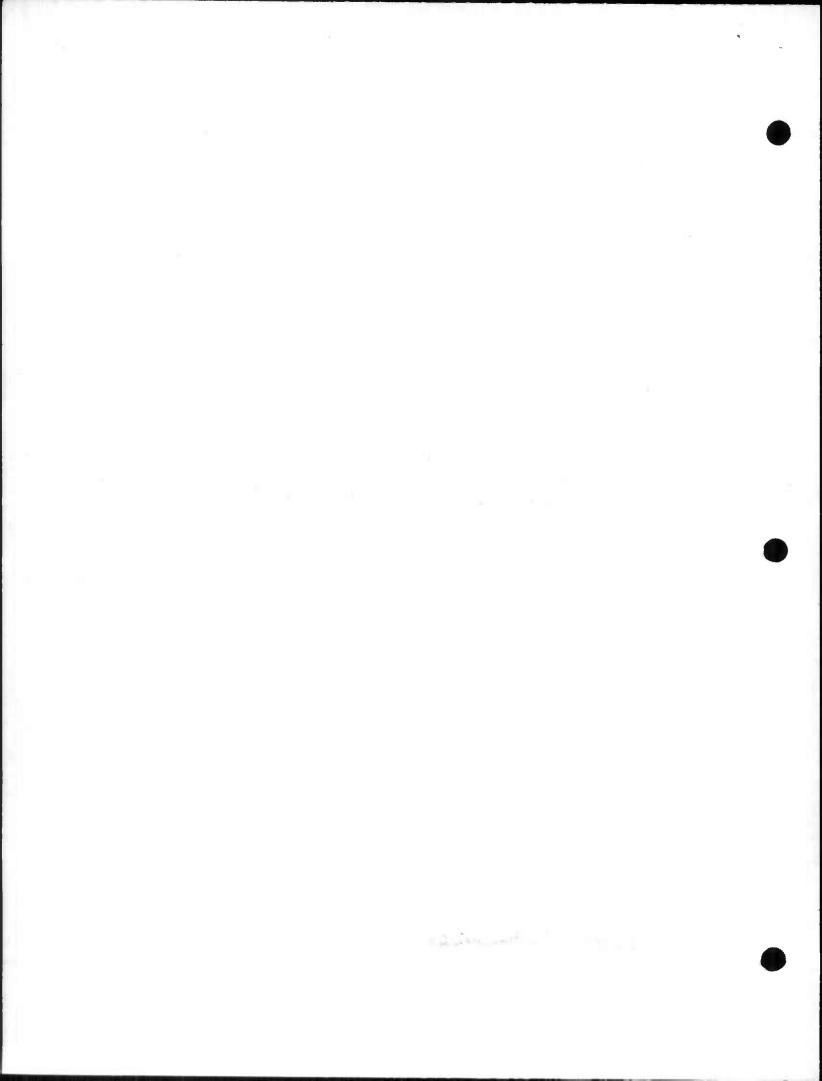
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be neitfied at once.

1 - STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	REGISTRAN		O.	-11011	OAIL		-7111		ned. NO.		_	
	1. DECEDENT'S NAME (First, Middle, Last)	الممالة 1			0.1777			M	DATE OF DEATH		YEAR	3. TIME OF DEATH
	14444	ildred			SNY				VEMBER 7	, 19		21:47 M
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. les		MONTHS DA	AR IF I	INDER 24 HRS.	(1	MATE OF BIRTH Month, Day, Year)		Countr	
	214-20-8376	YRS.					ecember 1		926	Maryland		
~	9e. FACILITY NAME (If not institution, give s				9b. CITY, TO						NTY OF D	EATH
DIRECTOR	THE JOHNS HOPK	CINS HOSP	PITAL		BA:	LTIMO	RE C	ITY		N	I/A_	
EG	10a. STATE 10b. COUNTY	10c. CITY	c. CITY, TOWN OR LOCATION						10d. INSIDE CITY			
8	Maryland Bai	Ra	ltimo	re						LIMITS? 1 YES 2 Y NO		
	10e. STREET AND NUMBER		1 011110	101. ZIP	CODE			10g. CITI	ZEN OF Y	VHAT COUNTRY?		
FUNERAL	7717 Eastdale Ro	ad					212	2/1		- 1	J.S.A	
Š	11. MARITAL STATUS	12. WAS DECEDEN	IT EVER IN U.S. AR	MED			NT OF HISP	ANIC O	RIGIN? (Specify Yes		14. RACE	- American Indian,
	1 Never Married 2 Married		YES 2 X	NO			NO Spe		erto Ricen, etc.)		Speci	t, White, etc.
ВУ	3 Widowed 4 Divorced					^						White
COMPLETED	15, DECEDENT'S EDU (Specify only highest grade		(G	ive kind of w	USUAL OCCU		working		16b. KIND OF BUS	INESS/IND	USTRY	
	Elementary/Secondary (0-12)	College (t-4 or 5	+) Hie	. Do NOT us	e retired.)				_			
MP	10			Clerk						on Oi	1 Cc).
8	17. FATHER'S NAME (First, Middle, Last)					18.			First, Middle, Malden			
BE	Joseph Hanus								eth Clar			
0	19a. INFORMANT'S NAME (Type/Print)		.19					al Route	Number, City or Town	, State, Zip	Code)	
-	Thomas E. Snyder	^			Same a							
	20s. METHOD OF DISPOSITION 1 X Burlet 2 Cremation 3 Ham	oval from State			of DISPOSITIO					CATION —	0	
	4 Donation 5 Other (Specify)	1	- Oak	lawn	Cemet					Balti	more	. Maryland
	21. SIONATURE OF FUNERAL SERVICE LIC	DENSIE	1		22. NAI	NE AND AI	DRESS OF	FACILIT Ruck	Funeral	Hom	e I	nc.
	Kmald C	black	h-								,	vland 21214
	23. PART I. Enter the diseases, or	complications the	at coused the de	sth. Do n	ot enter the	mode c	f dying, s	uch ss	cardisc or respi	ratory srr	rest,	Approximate
	ahock, or heert failure.	Liet orly one can	use on each line	ð.								Interval Between Onset and Death
	disesse or condition									20Ms		
	disease or condition s. SCP S\S DUE TO (OR AS A CONSEQUENCE OF):									1		
-		THOR	ACO AC	100	MALA	4	ORTI	`C	ANGUI	245		YEARS
CERTIFICATION	Sequentially list conditions, if any, isading to immediate	DUE TO	OR AS A CONSE	OUENCE OF	F):				ANGUR			1110
8	cause, Enter UNDERLYING	ATHO	ROSCLI	EROT CARDIOVASCULAR DISCA SEQUENCE OF:					240	= YEARS		
<u>i</u>		DUE TO	(OR AS A CONSE	OUENCE OF	UENCE OF):						46000	
	resulting in death) LAST	o KYPG	RIEU!	SCOU							ichtes	
	PART II. Other significant condition	as contributing to	death but not	reculting	ting In the underlying causs given in Part i. 24s. WAS /					ALITOPSY	. WERE AUTOPSY FINDINGS	
EDICAL				resulting in the underlying couss given in				PERFORMED?			AVAILABLE PRIOR TO COMPLETION OF CAUSE	
									1 TYES 2	NO		OF DEATH?
2	DID TOBACCO USE CONT	DIDLITE TO CA	LICE OF DE	TU VE	S NO		JNCERT/	AINL F	- I			1 TYES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL	KIBUIE IO CA			TH (Check only		JIACEKIA	-014				
2	EXAMINER?	HOSPITAL:	trae trae		OTHER:				0.0			
17.5	27. MANNER OF DEATH	28a. DATE O	☐ ER/Outpatient :	28b. TIM		c. INJURY		_	Other (Specify) 1. DESCRIBE HOW II	NJURY OC	CURED	
	1 Natural 5 Pending		Day, Year)		IURY	WORK?	2 NO					
BY	Accident Investigation	28a, PLACE I	OF INJURY — At h	ome term				281	. LOCATION (Street I	and Number	or Aural	Route Number
	3 Suicide 8 Could not be 4 Homicide determined		, etc. (Specify)		,,			1	City or Town, State)			
	29a. CERTIFIER		V V V V V V V V V V V V V V V V V V V							77		
AP	(Check only CEHTIFTINO PHYS	ICIAN: To the best o					- 30.6					A consequence
COMPLETED	2 MEDICAL EXAMINI	ER: On the basis of	examination and/or	Investigation	on, in my opir	lon, death	occured at	the time	, deta end placa, an	d due to th	he ceuse(s) and menner as stated.
ш	29b. SIGNATURE AND TITLE OF CERTIFIE	m),				29	. LICENSE I	NUMBER	1			(Month, Day, Year)
0 8	Deluces	The	フロ				4	04	7		VOI	7 1995
5	JO. NAME AND ADDRESS OF PERSON W	COMPLETED CAL	JSE OF DEATH (ITE	EM 27) (Type								21287
		COFSICI			HHL	C	000	N	- WOLF	CS	STE	733
	31. NOVO MONO 1995 Jall 32 RECUSTRANTS ENABURE											
	1.010 01330											



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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within A hours after death. Page 6 may be retained by the hospital or attending physician.

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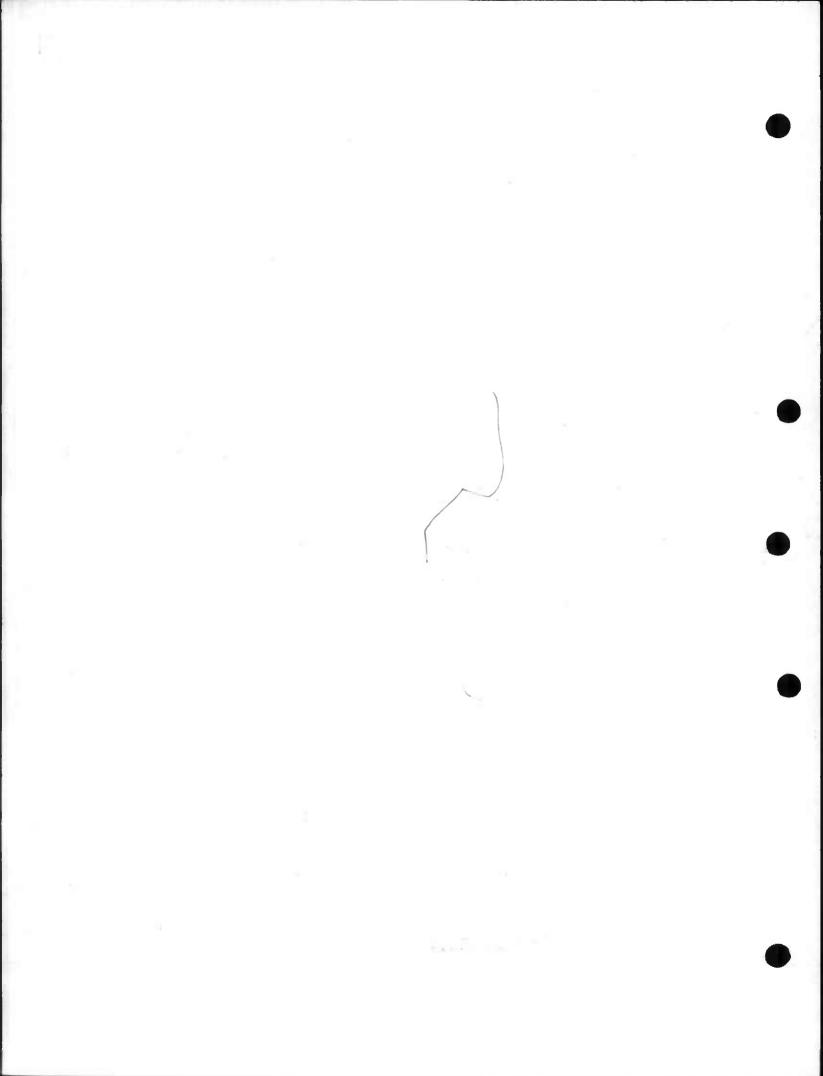
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STAT	E OF		DEPARTMENT			MENTAL	HYGIENE
		C	ERTIFICATE	OF DEAT	ГН		REG. NO.

1 - STATE REGISTRAR	STATE OF MARYLA		CATE OF	DEATH		REG. NO.		100	
1. DECEDENT'S NAME (First, Middle, Last					2. DATE O	OF DEATH DAY	YE	3. TIME OF DEATH	
Thomas.	James				NO	V-0	4 4	57 09040	
4. SOCIAL SECURITY NUMBER 247-54-8229	5. SEX 6. AGE (In	yrs. lest birthday) YRS.	MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.		Day, Year)		BIRTHPLACE (State or Foreign Country)	
Be. FACILITY NAME (If not institution, give	street and number) 0 SP, FW		96. CITY, TOWN O	la 1/5/20	EATH Un		Ba	OF DEATH	
10e. STATE 10b. COUN	NA	10c. CITY		10d. INSIDE CITY LIMITS? 1 VES 2 NO					
10e. STREET AND NUMBER			10	1. ZIP CODE			10g. CITIZEN	OF WHAT COUNTRY?	
36/0 Patters	1			2/207			4	, S.A	
1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 X YES IF YES, GIVE WAR OR DAT	2 NO	If yes, sp	CENDENT OF HISPA Decity Cuben, Maxico S 2 NO Specif	in, Puerto R		No- 14.	RACE — American Indian, Black, Whita, atc. Specify: Black	
15. DECEDENT'S ED (Specify only highest gra Elementary/Secondary (0-12)		16a. DECEDENT'S U (Give kind of w life. Do NOT use	ork done during me	ON ost of working	16b.	KIND OF BUSIN		er & Tailor	
12 in grade	2415	Dusin	2.55 0	wner					
17. FATHER'S NAME (First, Middle, Last)				16. MOTHER'S NA	ME (First, M	iddle, Meiden Su	rname)		
19a. JNFORMANT'S NAME (Type/Print)	ames	19h MAII ING	ADDRESS (Street	and Number or Rural	Della Bouto Mumb	T L	State Zin Con	41	
hois D. J	am on	2/0/6	Post	D for	200	2	1 L	1.12.	
20s, METHOD OF DISPOSITION	20b.1	BCACE AND DATEO	F.DISPOSITION (N	eme of	DATE		TION - City	or Town, State	
1 Burial 2 Cremation 3 Ra	moval from Stata ceme	tery, crematory or ott	ner plece) Fur	rest Vet	11/9/	5 0	Vina	5 Mills Md	
21. SIGNATURE OFFUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY MODELLE F. H. West 21.215									
23. PART I Enfer the diseases, o	complications that caused	The death. Do no	ot anter the me	300 ode of dying, suc	Uab	ash L	wenn tory arrest	e Baltomol	
23. PART I Enfer the diseases, o abock, or heart failure IMMEDIATE GAUSE (Final disease or pendition resulting in deeth)	r complications that caused List pnly one cause pn as a. CARD () DUE TO (OR AS A	ch lina.				25h A	Grenn tory arrest	interval Betwe	
IMMEDIATE (AUSE (Final disease or condition resulting in taeth) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury	a. CAROLO DUE TO (OR AS A DUE TO (OR AS A C.	CONSEQUENCE OF	ARY):			ash A	Avena tory arrest	interval Betwe	
IMMEDIATE dAUSE (Final disease or condition resulting in tach) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	a. CARDIO DUE TO (OR AS A SA CARDIO)	CONSEQUENCE OF	ARY):			ash A	Ovenn tory arrest	e Balto M. Approximate interval Betwee Onaet and Das	
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TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with 24 hours after death. Page 6 may be retained by the hospital or attending ph	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the but he filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlal, cremation, or removal.	IMPORTANT Hism 28 is marked or item 23 shows any injury or other traumatic event the medical evamines must be notified at once
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ITEM: 3. PER DR. FILM G-729 11/14/95 t.t STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - STATE REGISTRAR CERTIFICATE OF DEATH REG. NO. 2. DATE OF OEATH t. OECEDENT'S NAME (First, Middle, Last) 11:56 RUBY HELEN TELESCA 1995 11:45 A November 6 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) MONTHS DAYS HOURS 1 □ M 2 😾 F 433-01-5212 June 22, 81 1914 Louisiana Se. FACILITY NAME (If not institution, give street end number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Dulaney Towson Nursing Home Towson Baltimore DIRECTO 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Baltimore 1 YES 2 1 NO Towson FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 911 Beaverbank Circle 21286 USA 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No—If yes, specify Cuban, Mexican, Puerto Ricen, etc.)

1 YES 2 NO Specify: 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 14. RACE — American Indian Black, White, etc. FORCES? 1 YES 2 NO 1 Never Married 2 Merried Specify. BY 3 Widowed 4 Divorced White ETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 166 KIND OF BUSINESS/INDUSTRY (Specify only high (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) COMPL Homemaker at home 17. FATHER'S NAME (First, Middle, Last) 18 MOTHER'S NAME /First Middle Meiden Sumame Charles A. Dancy Beatrice Bandera BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Mr. Donato R. Telesca 911 Beaverbank Circle Towson, Maryland 21286 200. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State | Burlet 2 | Cremation 3 | Removal from State
| Donation 5 | Other (Specify)
| Signature | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Compa Dulancy Valley Maus 11/9/95 Cockeysville Maryland Ruck Towson Funeral Home, Inc. 1050 York Rd Carl angge 23. PART I. Enter the diseases, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fellure. List only, an each line. Interval Between Onset and Death IMMEDIATE CAUSE (Finel disease or condition HIZ her mers reaulting in death) CERTIFICATION Sequentially list conditiona, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Entar UNDERLYING CAUSE (Diseese or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO MEDICAL COMPLETION OF CAUSE 1 TES 2 NO OF DEATH? 1 - YES 2 - NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\Boxed{1}\) NO \(\mathbb{Z}'\) UNCERTAIN \(\Boxed{1}\) PHYSICIAN: 26. PLACE OF DEATH (Check only one 25. WAS CASE REFERRED TO MEDICAL OTHER:

Nursing Home 8 - Residence 8 - Other (Specify) HOSPITAL: 1 YES 2 NO ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK?
1 YES 2 NO 1 Natural 2 28d. DESCRIBE HOW INJURY OCCURED 5 Pending Investigation BY Accident 28e. PLACE OF INJURY — At home, ferm, street, fectory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be ETED 4 Homicide 29e. CERTIFIER (Check only one) CERTIFING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end menner ee atsted. COMPL investigation, in my opinion, death occured at the time, date end place, and due to the cause(s) end menner as stated. 29c. LICENSE NUMBER 29d DATE SIGNED (Month Day Year) BE 7 NOV 1993 2

Joseph W. zebley,

III, M.D. 7801 York Road 32. REGISTRAR'S SIGNATURE

DATE FILED (Month, Day, Year) NOV 0 91995

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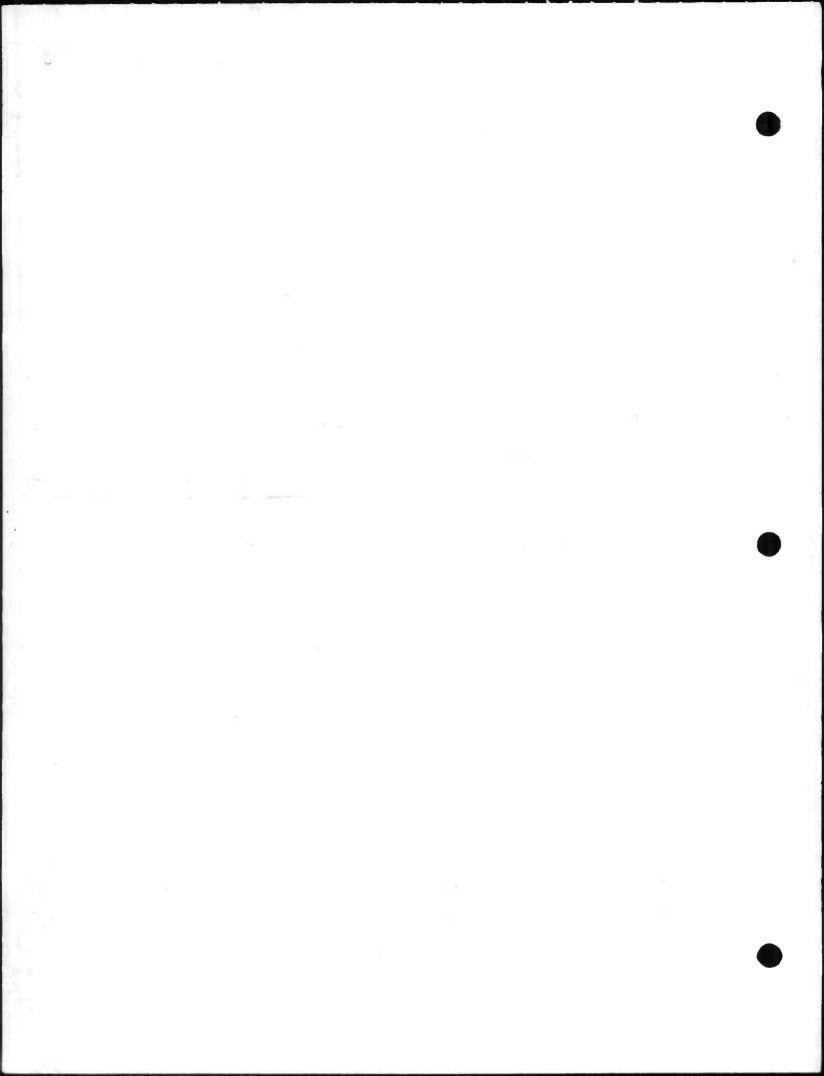
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH
REG. NO.

	1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH													
			Robert	Vano	rhn					Novem	her)1 1	WEAR	1:45p.m. M
	4. SOCIAL SECURITY NUMBER	BER	5. SEX		s. last birthday)	IF UNDE	R 1 YEAR	IF UNDER	24 HRS.	7. DATE OF F	BIRTH			LACE (State or Foreign
	127-26-3008		1 🖟 M 2 🗆 F	1 XM 2 DF 60		MONTHS	DAYS	HOURS	MIN.	(Morith, De	onth, Day, Year) Cou		Country)	
	9a. FACILITY NAME (If not in							OR LOCATI		7 - 7	17	9c. COU	NTY OF DE	ATN
OR	6311 Maxwel		Ca	Camp Springs Prince Geo					George's					
ווו	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION													
DIRECTOR	Maryland		ump S								10d. INSIDE CITY LIMITS? 1 YES 2 NO			
FUNERAL	6311 Maxwel				20748				10g. CIT	IZEN OF WI	IAT COUNTRY?			
BY	11. MARITAL STATUS 1 Never Merried 2 3 Widowed 4 Divo	T EVER IN U.S X YES 2 VAR OR DATES	□ NO		If yes, sp	ENDENT Cooling	n, Mexica	IIC ORIGIN? (Sen, Puerto Ricen	pecify Yee o	or No-	14. RACE - Black, Specify.	14. RACE — American Indian, Black, White, etc. Specify: Black		
9		EDENT'S EDUC y highest grade		164	DECEDENT'S					16b, KIN	D OF BUSI	NESS/INC	DUSTRY	
9	Elementary/Secondary (0		College (1-4 or 5	+1	(Give kind of life. Do NOT u	se retired.)	aunng ma	st of worki	10	1				
MP	12				MILIT	ARY					AIR F	ORCE		
COMPLETED	17. FATHER'S NAME (First, M.	iddle, Last)						18. MOTI	NER'S NA	ME (First, Middle	e, Maiden Si	umame)		
BE				NOWN					UNKNO					
2	190. INFORMANT'S NAME (7) Mr. Lynn	Spe/Print) (6	riend)		l					Noute Number, C			Code)	
	20g, METHOD OF DISPOSITI	ION							uitl	and, N			207	
	1 🕅 Buriel 2 🗆 Cremetto 4 🗆 Donation 6 🗀 Other	(Specify)()	State	_ cometed	ACEAND DATE	NATIO	NAL			11/21	ARL	INGTO	N City or Town, State	
										NERAL HOMES				
	21. SIGNATURE OF POMERAL SERVICE LICENSEE RONALD Wade, Dir. 22. NAME AND ADDRESS OF FACILITY ALEXANDER S. POPE FUNERAL THE STATE AND STATE OF THE S									1715LE 10.				
NOI	23. PART I. Enter the diseases, or complications that ceused the desth. Do not enter the mode of dying, such as cerdiac or reepiratory errest, ahock, or heart failure. Liet only one cause on each line. IMMEDIATE CAUSE (Final disease or condition reaulting in desth) Diabetic arteriosclerotic cardiovascular disease DUE TO (OR AS A CONSEQUENCE OF): Sequentielly list conditions.													
CERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):													
	PART II Other elgolfice	ot condition	a contribution to	doub but a		- at-								
MEDICAL	TATE II. Otto agililico	THE CONGRESSION	e contributing to	deeth but h	iot reeuiting	g in the underlying ceuse given in Part					PERFORM	ED?	á	VERE AUTOPSY FINDINGS WARLABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
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AN	DID TOBACCO US		CIBUIE IO CA		PLACE OF DEA			UNC	EKIAIN	V LX				
PHYSICIAN:	EXAMINER? 1 YES 2 NO		HOSPITAL:			OTHE	R:	V-		- Cle:				
¥ ∥	27. MANNER OF DEATH		28e. DATE OF		26b. TIN		28c. JNJ		sidence	6 Other (Spe 28d. DESCRIB		IURY OC	CURED	
ВУ Р	2 Accident	Pending investigation	(Month, D		IN.	M	1 🗌 1	RK? res 2	NO					
TED		Could not be determined	26e. PLACE O building,	etc. (Specify)	it home, term,	street, fact	lory, offici			281. LOCATION City or Tox	N (Street end wn, State)	d Number	or Rural Roo	ste Number,
COMPLETED			CIAN: To the best of											and manner es stated.
TO BE C	296. SUGGESTURE AND TITLE JULIANIES AND ADDRESS OF	Low	njues	m	7				230	BER	/	200 PATE	e signed (Joreth, Day, Year)
	Augusto P.	Rod	raguez	M.D.	5009		bur	n Ct	.,	Camp	Spri	ngs	, MD	20748
	Augusto P. Rodráguez M.D. 5009 Rayburn Ct., Camp Springs, MD 20748 1. DATE FILED (Month, Day, Year) 1. DATE FILED (Month, Day, Year) 1. DATE FILED (Month, Day, Year) 1. DATE FILED (Month, Day, Year) 1. DATE FILED (Month, Day, Year)													



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FOR STATE REGISTRAR CERTIFICATE OF DEATH REG. NO. 1. OECEOENT'S NAME (First, Middle, Last) 2. DATE OF CEATH 3. TIME OF DEATH Nov 8 1995 1:05 amu **EMANUEL VENDELIS** Andrew 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH 5. SEX 8. AGE (In vrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign MONTHS DAYS HOURS Sept. 10, 1916 1 X M 2 - F 215-09-0928 Greece 9a, FACILITY NAME (If not institution, give street end number 9b. CITY TOWN OR LOCATION OF DEATH 9c COUNTY OF DEATH Baltimore DIRECTOR Towson, Maryland Saint Joseph Medical Center RESIDENCE OF DECEDENT 10e. STATE 10d, INSIDE CITY LIMITS? 10b. COUNTY Baltimore Co. Maryland Towson 1 YES 2 YNO 10e. STREET AND NUMBER 101. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? FUNERAL 21286 U.S.A. 205 East Joppa Road Unit #606 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-14. RACE — American Indian, Black, White, etc. If yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1 Never Married 2 X Married 1 TES 2 X NO Specify: Specify: White BY 3 Widowed 4 Divorced 18e. DECEDENT'S USUAL OCCUPATION ETED 15. DECEDENT'S EOUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade comp Elementary/Secondery (0-12) College (1-4 or 5 +) COMPL 12 Self Employeed Restauranture Restaurant 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malden Surname) Ħ Vespina Apostolakis Andrew Emanuel Vendelis BE notified 19e, INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Mrs. Helen D. Vendelis 205 East Joppa Road Unit #606 Towson, Md. 21286 pe 20e. METHOD OF DISPOSITION DATE 20c. LOCATION — City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of must 1 Surial 2 Cremetion 3 Removal from State
4 Donation 5 Other (Specify) St. Demetrios Ch.Cem. Nov. 10,95 Cub Hill, Maryland Leonard J. Ruck, Inc. examiner SIGNATURE OF FUNERAL SERVICE LICENSEE Jeffrey L. Gair 0 air 5305 Harford Road Baltimore, Maryland 21214 23. PART I. Enter the diseases, or complections that caused the death. Do not enter the mode of dying, such as cardiac or respiratory street, abook, or heart failure. List only one cause on each line. medical Approximate Interval Between Onset and Death IMMEDIATE CAUSE (Final the disease or condition MASSIVE PULMONARY EMBOLISM 30-40 MIR reaulting in death) event. DUE TO (OR AS A CONSEQUENCE OF): SMALL BOWEL OBSTRUCTION DAYS traumatic CERTIFICATION Sequentially list conditiona, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING HYPERTENSION YEARS other t CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated eventa reaulting in death) LAST 10 Injury. PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part 1. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL PERFORMEO? AMAILABLE PRIOR TO ашу COMPLETION OF CAUSE OF DEATH? 1 TES 2 NO Shows 1 TES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO IN UNCERTAIN PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one Item HOSRUTAL:
1 | Invation: 2 | ER/Outpatient 3 | DOA OTHER: 1 YES 2 NO 4 Nursing Home 5 Residence 8 Other (Specify) 6 27. MANNER OF DEATH 28e. DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED is marked, 1 Newtral
2 Accident 5 Pending Investigation 1 YES 2 NO BY 3 Sulcide 28s. PLACE OF INJURY — At home, ferm, street, fectory, office building, stc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, 8 Could not be COMPLETED 4 Homicide 28 Item 29e. CERTIFIER

(Chack note of the course) To the best of my knowledge, dasth occurred at the time, data end piece, and due to the course(e) end menner ee stated. TO THE HOSPITAL OF TO THE FUNERAL D DE filed within 72 ho IMPORTANT: If Its 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(e) and menner as stated. MATURE AND TITLE OF CENTIFIER

Condo 29c. LICENSE NUMBER 29d. DATE SIGNED (Month) Day, Year) BE 8 95 Damero D 28982 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ERLANDO ROMERO, MD 7620 YORK ROAD TOWSON, MARYLAND 21204 NOV 0 9 1995 32 REGISTRAR'S SIGNATURE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

PERSONAL DESIGNATIONS

ACCUPATION TO THE PROPERTY OF

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Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020 death.

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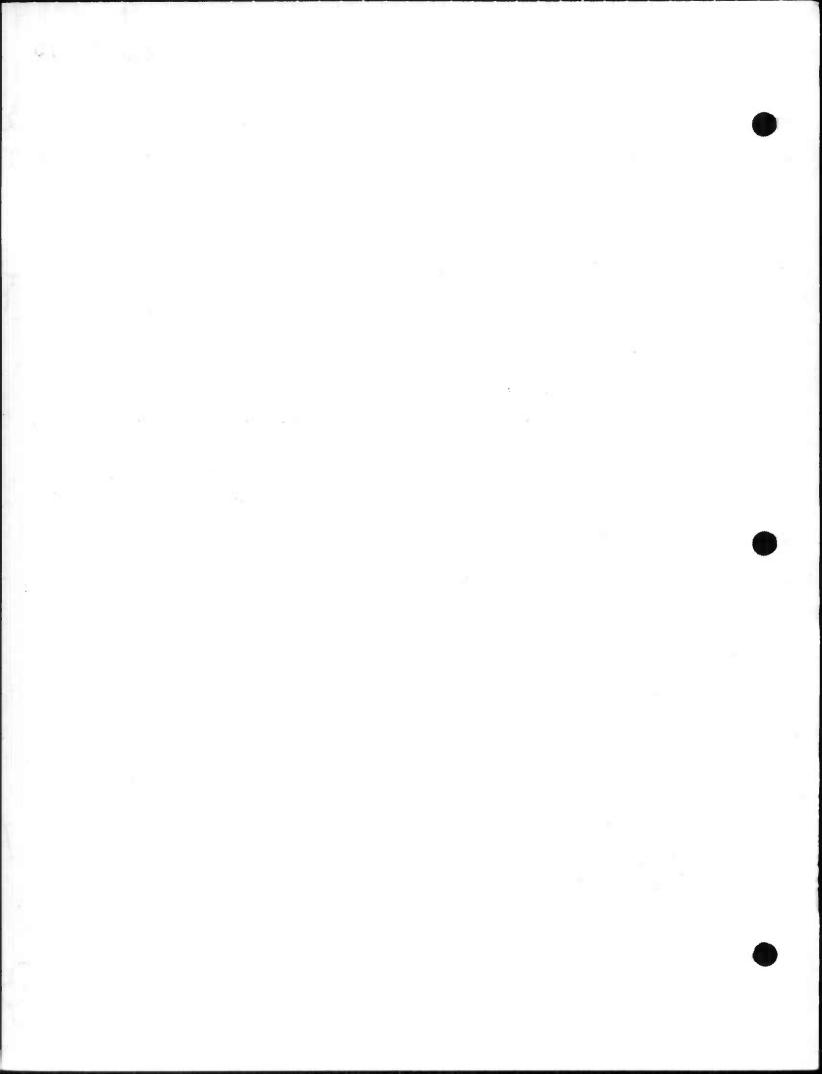
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DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ex hours a	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by be filled within 72 hours after death with the State Dent. of Health and Mental Hotelee brior to burial, cremation, or nem	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medic
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S HAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH Phv1lis WRIGHTSON November 995 6:20 a M 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIFTH (Month, Day, Year, 8. BIRTHPLACE (State or Foreign DAYS 1 M 2 F HOURS April15,1940 55 WestVirginia 213-38-6129 YRS. Se. FACILITY HAME (If not institution, give street and number, 9b. CITY. TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Franklin Square Hospital Rossville Baltimore RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c, CITY, TOWN OR LOCATION 10d. IHSIDE CITY LIMITS? 1 YES 2 HO Md. Baltimore Middle River 10e. STREET AND NUMBER FUNERAL 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 18 Decater Road 21220 USA 13. WAS DECEMDENT OF HISPAHIC ORIGIN? (Specify Yee or No—
If yee, specify Cuben, Mexicen, Puerto Rican, etc.)
1 YES 2 NO Specify: 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 14. RACE — American Indian, Black, White, atc. FORCES? 1 YES 2 NO 1 Never Married 2 X Merried B Specify: 3 Widowed 4 Divorced White COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade (Give kind of work done during most of working life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) 8th Housewife own home 17. FATHER'S HAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) BE Caspy Loudermilk Alice 19e. IHFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 18 Decater Road Baltimore Md. 21220 Robert Wrightson 20e. METHOD OF DISPOSITIOH
1X Burlal 2 Cremetton 3 Removal from State 28c. LOCATION — City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE Holly Hill Cemetery 11/10/95 BAltimore Md. 4 Donation 5 Other (Specify) 21. SIGHATURE OF FUNERAL SERVICE LICENSEE 22. HAME AND ADDRESS OF FACILITY Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 23. PART I. Enter the diseases, or complications that caused the deals shock, or heart feliate. List only one cause on each line. Do not anter the mode of dying, such as cardisc or respiratory errest, interval Between IMMEDIATE CAUSE (Final Onset and Death disease or condition Lung cancer 5 days resulting in death) DUE TO (OR AS A CONSEQUENCE OF): b. Cancer in bone marrow DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION 1 month Sequentially list conditions, if any, lasding to immediate cause. Enter UNDERLYING Cervical cancer 30 years CAUSE (Disesse or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 1 TYES 2 XT HO OF DEATH? 1 TYES 2 THO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES 🔯 NO 🗌 UNCERTAIN 🗆 PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL:
14 Inpatient 2 ER/Outpatient 3 DOA OTHER: 1 - YES 2 NO ng Home 5 - Residence 8 - Other (Specify) 27. MANHER OF DEATH 28e. DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural M 1 YES 2 HO BY Investigation 2 Accident 26e. PLACE OF IHJURY — At home, ferm, street, fectory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be COMPLETED 4 Homicide 29e. CERTIFIER 1 🖰 CERTIFYING PHYSICIAH: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(e) and manner as stated. (Check only one) 2 MEDICAL EXAMIHER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner as stated. 296. BIGNATURE AND TITLE OF CENTIFIER 29d. DATE SIGNED (Month, Day, Year) 29c. LICENSE NUMBER BE 11795 4665 5 AND ADDRESS OF PERSON W COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Eldeiry Samer M.D. 9000 Franklin Square Drive, Baltimore MD. 21237 32. REGISTRAR'S SIGNATURE
JULIA DRUGE RANGELL 31. DATE FILED (Month, Day, Year) NOVO 91995



BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be netified at once.

DIVISION OF VITAL RECORDS, P.O. BOX 68760

Items1,4,6,7,8,10a,10b,10c,10e,10f,10g,11,12,13,14,16a,16b,19a,19b

1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		EKIIF	CALE	F DEATH	R	IEG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last) Ruth	Carol Wa	Mar	ER		2. DATE OF MONTH	MBER 5	1995	3. TIME OF DEATH 9:00 AM	
	4. SOCIAL SECURITY NUMBER 5. SEX 115-18-4531 1 1 M 2 12	5. SEX 1 M 2 M F 8. AGE (In yrs. lest birthday) YRS. 1 MONTHS DAYS HOURS MHN. 70 YRS. 1 UNDER 1 YEAR IF UNDER 24 HRS. (Month, Day, Year) Nov 08,19							LACE (State or Foreign	
	9a. FACILITY NAME (If not institution, give street and number		9b. CITY, TOV	N OR LOCATION OF DE			UNITY OF DE			
DIRECTOR	5043 Branchville Road		Colle	ge Park				EURGES		
E C	10a. STATE 10b. COUNTY		10c. CITY	, TOWN OR LO	CATION			10d, INSIDE CITY		
	MD Prince Geo	rge	A	delphi				LIMITS?		
FUNERAL	10e. STREET AND NUMBER			10f. ZIP CODE		10g. Cl	TIZEN OF WH	IAT COUNTRY?		
E	7900 Kreeger Drive #1	n2			20783		п.			
5	11. MARITAL STATUS 12. WAS DEC	EDENT EVER IN U.S. 1 YES 2	ARMED		ECENDENT OF NISPAN		pecify Yes or No-	14. RACE -	- American Indian,	
ВУ	The Never Married 2 Married IF YES, G	IVE WAR OR DATES	Kuo		specify Cuban, Mexica ES 2 NO Specify		n, etc.)	Specify.	White, etc.	
				1	Λ				Thite	
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)		(Give kind of w	OSUAL OCCUP	NTION most of working	16b. KIN	ID OF BUSINESS/IN	DUSTRY		
ا ت	Elementary/Secondary (0-12) College (1-4	or 5 +)	Iffe. Do NOT us	e rearea.)		-				
Ž	17. FATHER'S NAME (First, Middle, Lest)		Nurse				S. Gove	nment		
	17. FAITHER'S HAME (FIRST, MICUIN, LIIST)				18. MOTHER'S NA	ME (First, Middl	e, Malden Surname)			
BE	19a. INFORMANT'S NAME (Type/Print)		105 1141 100	ADDRESS (O-						
2	Paul H. Terry				et and Number or Rural I				705	
	20a. METHOD OF DISPOSITION	205 01 40		FDISPOSITION	lawn Road,		20c. LOCATION -		705	
	1 Burtel 2 Cremetion 3 Removal from State 4 Donation 5 Typine (Specify) 412 STATE	e cemetery,	crematory or oti	her place)		1				
	21. SIGNATURE OF THE BERL SERVICE LICENSEER ON	7 62	Dir.	22. NAME	AND ADDRESS OF FA	1-11-9	5 Catons	ville	,MD	
	100000000000000000000000000000000000000	la water,	04/6.	State	Anatomy	Board-	655 W. B	Baltim	ore Street	
-	Johnson II W	me		Rm.B	126-Baltim	ore, M	aryland	212	01-1559	
	23. PART I. Enter the disease, or complications abook, or heart failure. List only one IMMEDIATE CAUSE (Final disease or condition resulting in death)	cause on each if	ne.		RCTION		or respiratory e	reat,	Approximata interval Between Onset and Death	
Z		E TO (OR AS A CONS	SEQUENCE OF):						
CERTIFICATION	cause. Enter UNDERLYING	E TO (OR AS A CONS	SEQUENCE OF):						
Ĕ	man millered eventes	E TO (OR AS A CONS	EQUENCE OF):						
	resulting in death) LAST									
	PART II. Other aignificant conditiona contribution	g to death but no	t resulting is	the underly	ing cause alves in	Part i Ota	. WAS AN AUTOPSY	Lan		
EDICAL						Part 1. 248	PERFORMED?	A	VERE AUTOPSY FINDINGS WAILABLE PRIOR TO COMPLETION DF CAUSE	
	Dishetes mellitus, me morbid obesity	M-MOM	un de	penae	ux	- 10	YES 2 NO		OF DEATH?	
Σ	DID TOBACCO USE CONTRIBUTE TO							1	☐ YE\$ 2 ☐ NO	
AN	25. WAS CASE REFERRED TO MEDICAL			H (Check only o		ч Ц				
Sic	EXAMINER? 1 V YES 2 NO 1 Ingesters			OTHER:	A					
PHYSICIAN:		E OF INJURY	28b. TIME		ome 5 Residence		BE HOW INJURY OC	CHRED		
ВУ Р	1 Netural 5 Pending 2 Accident Investigation	nth, Day, Year)	INJU	M 1 [WORK? YES 2 NO	EGG. DEGGINE	SE NOW INSOME SE	JOHED		
COMPLETED	3 Suicide 6 Could not be 4 Homicide determined	CE OF INJURY — At ding, etc. (Specify)	home, farm, a	lreet, factory, o	fice	28f. LOCATIO	N (Street and Numbe wn, State)	or Rural Rou	ste Number,	
1 2	29e. CERTIFIER (Check only) 1 CERTIFYING PHYSICIAN: To the be	est of my knowledge,	death occurre	d at the time, d	te and place, and due	to the cause(s)	and manner as ste	ted		
N N	one) 2 MEDICAL EXAMINER: On the basis								and manner as stated.	
	29b. SIGNATURE AND TITLE OF CERTIFIER									
TO BE	of Boyen MD				0259	25	►N	ov 6,	1995	
	30. NAME AND ADDRESS OF PERSON WHO COMPLETED J. BERGER MD #205 31. DATE, EILED (Month, Day, Year) 32. REGI	CAUSE OF DEATH (IT	WIS	Print)	N Ave. 1	BeThe	sda Md	Z	2814	
		STRAR'S SIGNATURE	7 48				1/10			
	NOV 09 1895 Julia	andre hard	(all)							
	ALL DE LA CONTRACTOR DE									

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BALTIMORE, MARYLAND 21215-0020 the death. Page 6 may be retained by the hospital or attending physician. The funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospit	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached		IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
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1 24	y fille	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial. cremation, or removal.	the
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30. NAME AND ADDRESS OF PERSON WHO SOME LITTED CAUSE OF DEATH (ITEM 27) (Type, Print)

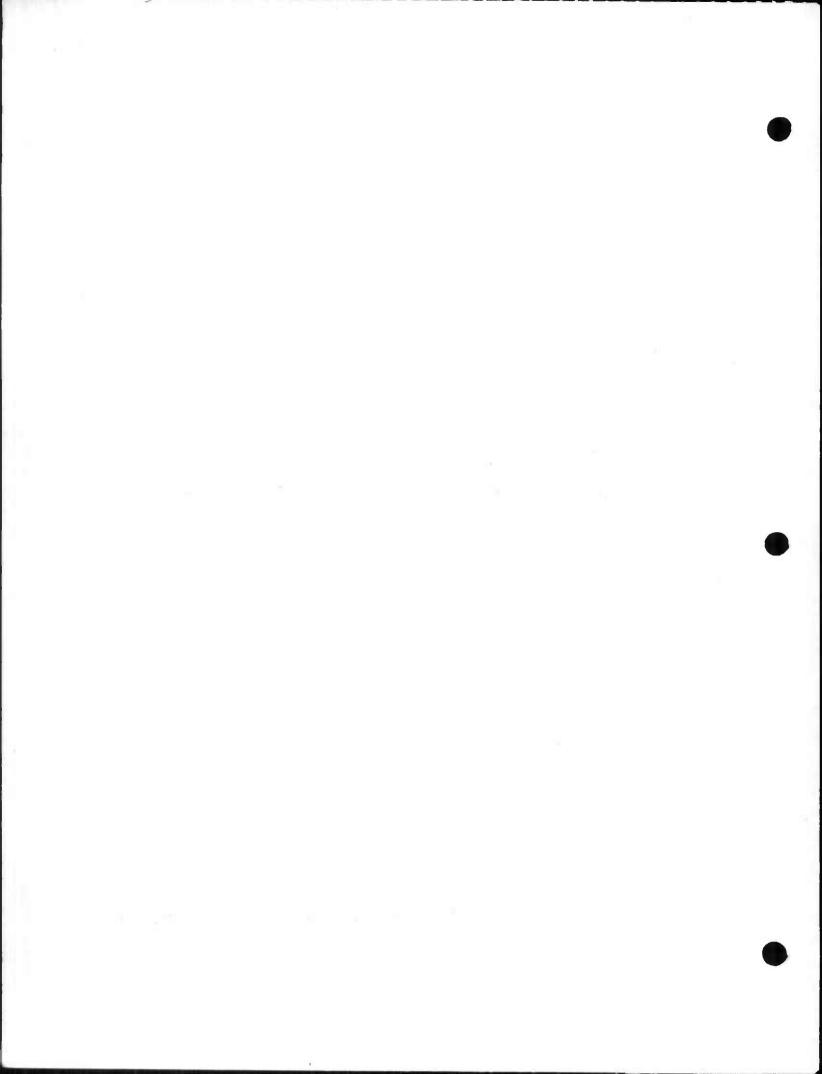
32. REGISTRAR'S SIGNATURE

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FOR 1 - STATE REGISTRAR	STATE OF I	MARYLAND /	DEPAR						YGIENE				
1. DECEDENT'S NAME (First, Middle, Last)								2. DATE OF	DEATH	_		3. TIME OF DEAT	4
GRACE				M	IAGN	ER	00	CTOBE		, 1	995	10:10	A
4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. las	st birthday)	IF UNDER		IF UNDER		7. DATE OF	BIRTH		8. BIRTH	PLACE (State or Fo	eign
	1 M 2 XF	74	YRS.	MONTHS	DAYS	HOURS	MIN.	(Month, D	wy, 16ar)		Country	y)	
9s. FACILITY NAME (If not institution, give-	street and number)			9b. CITY	TOWN O	R LOCATIO	N OF DE	ATH		9c. COU	INTY OF D	EATH	
400 COMIL DIAC	E.			CEA	ת יווי	LEAS	יז א אזר	T		DD	TNCE	E GEORG	T.C
408 69TH PLAC	<u> </u>			SEA	AI P	LEAS	SAN.	1		PK	INCE	GEORG	E O
10a. STATE 10b. COUNT				Y, TOWN C	_							10d. INSIDE CITY	
Maryland Princ	e George	\$	Sec	at P	leas	ant						1 YES 2	NO
10e. STREET AND NUMBER						ZIP CODE				10g. CIT	TIZEN OF W	VHAT COUNTRY?	
408 69th Place						20743	3						
11. MARITAL STATUS		NT EVER IN U.S. AF						VIC ORIGIN? (S		or No-	14. RACE	- American India	n,
1 Never Married 2 🔀 Married		NAR OR DATES	NO			city Cuber 2 NO		n, Puerto Rica v:	en, atc.)		Speci	y: White	
3 Widowed 4 Divorced													
15. DECEDENT'S EDU (Specify only highest grad	ICATION completed)	16a. DE	ECEDENT'S Sive kind of v	USUAL O	CCUPATIO	N at of working	2	16b, KI	ND OF BUSI	NESS/IN	DUSTRY		
Elementary/Secondary (0-12)	College (1-4 or 5	- Illia	. Do NOT us		outing the	it or working	,						
17. FATHER'S NAME (First, Middle, Last)						18. MOTH	ER'S NA	ME (First, Midd	dle, Meiden S	lurname)			
19a, INFORMANT'S NAME (Type/Print)	husband)	19	b. MAILING	ADDRESS	S(Street a	nd Number	or Rural I	Route Number,	City or Town,	State, Zi	ip Code)		
Herman Wagner		4	108 6	9th	Plac	e-Sec	it P	leasar	rt, Mo	rryl	and	20743	
20a. METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 Rer	nound tone Otata	20b. PLACE			ITION (Na	ma of		DATE	20c. LOC	ATION -	- City or To	nvn, Stata	
4 Donation 5 C Other (Specify) 4.	State	cemetery, cri	ematory or o	ther place)									
21. SIGNATURE OF FUNERAL SERVICE L	CENSEERONAL	d Wade.	Dir.	22.	NAME AN	D ADDRES	S OF FA	CILITY	1 /FF	(.)	D-0+	imaka Cd	
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10 miles	ano	·										201-1559	
23. PART I. Enter the diseases, or ahock, or heart failure				not enter	tha mo	da of dyle	ng, auc	h aa cardia	c or reapin	etory a	rreat,	Approximation Interval B	
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disease or condition resulting in death)	Atheroschofic Condisvascular Discuse												
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CAUSE (Disease or Injury	C	OR AS A CONSE	OUTUOE O	-		_							
that initiated events resulting in death) LAST	DOE IV	OH AS A CONSE	OUENCE O	ey:								i	
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PART II. Other algnificant condition	na contributing to	death but not	reaulting	In the ur	nderlying	cause g	lven in	Part I. 24	4a. WAS AN		24b	WERE AUTOPSY FI	
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25. WAS CASE REFERRED TO MEDICAL	T C		CE OF DEA			0110	LKIMI	14 (3)					
EXAMINER?	HOSPITAL:			OTHE	R:	7.5						·	
1X YES 2 NO		□ ER/Outpetient	28b. TIM				sidenca	6 Other (S		IIII O	OCH INTO		-
27. MANNER OF DEATH 1 Netural 5 Pending	28a. DATE O (Month,	Day, Year)		JURY		RK?	1	200. DESCR	HIBE HOW IN	JUNY O	CCORED		
2 Accident Investigation		OF IN HIP ALL		etmat. fr		/ES 2 _	NO	201 / 00/5	ION (Company)	ad Marian	as as Princip	Bouts Museber	
3 Suicide a Could not be determined		OF INJURY — At h j, etc. (Specify)	ome, Term,	wireel, fac	tory, offic				ION (Street as Town, State)	na Numb	er or Hural i	Route Number,	
CONSCRIPTION OF THE PROPERTY O	SICIAN: To the best of	of my knowledge, d	leath occurr	red at the 1	lime, dete	and place,	and due	to the cause	(s) and man	ner as st	sted.		
one) 2 X MEDICAL EXAMIN	ER: On the basie of	axamination and/or	Investigation	on, in my	opinion, d	eath occur	ed at the	time, deta an	nd piace, and	dua 10	the cause(s) and manner as s	usted.
29b. SIGNATURE AND, TITLE OF CERTIFI	ER /	7 1				29c. LICE	NSE NUI	MBER	T	29d. DA	TE SIGNED	(Month, Day, Year)	

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OCTOBER

Penn Street, Baltimore, Maryland



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BALLIMORE, MARY	TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at
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DIVISION OF VITAL RECORDS, P.O. BOA 80700	100	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the field within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	E
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 -CERTIFICATE OF DEATH REG NO 1. DECEDENT'S NAME (First, Middle, Last) Phyllis Ann Irene Webb, 2. DATE OF DEATH DAY 3. TIME OF DEATH YEAR WEBD PHYLLIS NOVENBER 1995 1110 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign MONTHS DAYE 34 215-64-8884 1 M 2 YF July 4. Maruland 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Baltimore Northwest Hospital Center Randallstown RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Owings Mills Baltimore Maryland 1 TYES 2 NO 10e. STREET AND NUMBER FUNERAL 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? Rosewood Center-Owings Mills, MD. 21117 21117 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No—If yee, specify Cuben, Maxicen, Puerto Rican, etc.)

1 YES 2 X NO Specify: 14. RACE — American Indian, Black, Whita, atc., Specify AMCT4 Can FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES 1 X Never Married 2 Married BY 3 Widowed 4 Divorced Indian 16a. DECEDENT'S USUAL OCCUPATION ETED 15. DECEDENT'S EDUCATION 165 KIND OF BUSINESS/INDUSTRY Elementary/Secondery (0-12) College (1-4 or 5 +) COMPL Disabled 17. FATHER'S NAME (First, Middle, Last) Phyllis Charlotte Webb "Lange" Lawrence Webb B. INFORMANT'S NAME (Type/Print) 196. MAILING ADDRESS (Screen and Number or Averil, Pourle Number, City or Town State, 219, Code) Land 21222 Mr. & Mrs. Lawrence Webb 20e. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE Burisi 2 Cremation 3 Removal from State N Donetion 5 □ Other (Specify) 21. SIGNATURE OF MERAL SERVICE LICENSEE Ronald Wade, Dir. 22. NAME AND ADDRESS OF FACELITY State Anatomy Board-655 W. Baltimore Street Rm. B026-Baltimore, Maryland 21201-1559 anoun 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ahock, or heart fellure. List only one cause on each lins. Onset and Death IMMEDIATE CAUSE (Final disease or condition CARDIAC ARREST 5 MINUTES reaulting in death) DUE TO (OR AS A CONSEQUENCE OF): RESPITORY ARREST 5 TINUTES CERTIFICATION Sequentielly list conditions. DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING PNEUMONIA ASPIRATION 3 WEEKS CAUSE (Diseese or injury DUE TO (OR AS A CONSEQUENCE OF) that initiated eventa reaulting in death) LAST PART II. Other aignificant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY 24b. WERF AUTOPSY FINDINGS MEDICAL AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? SEIZURES t TYES 2 PINO MENTAL RETARDATION t TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO X UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only OTHER:
4 □ Nursing Home 5 □ Realdenca 6 □ Other (Specify) HOSPITAL:
1 | Inpetiant 2 | ER/Outpetient 3 | DOA 1 - YES 2 NO 27. MANNER OF DEATH 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending Investigation 1 YES 2 NO BY 2 Accident 28a. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 8 Could not be COMPLETED 4 Homicide 29e. CERTIFIER
1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data end place, and due to the cause(s) and manner se stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Day, Year) BE KN_ K.S. RAO.MI.O MOVERIBER 6 1905 043462 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

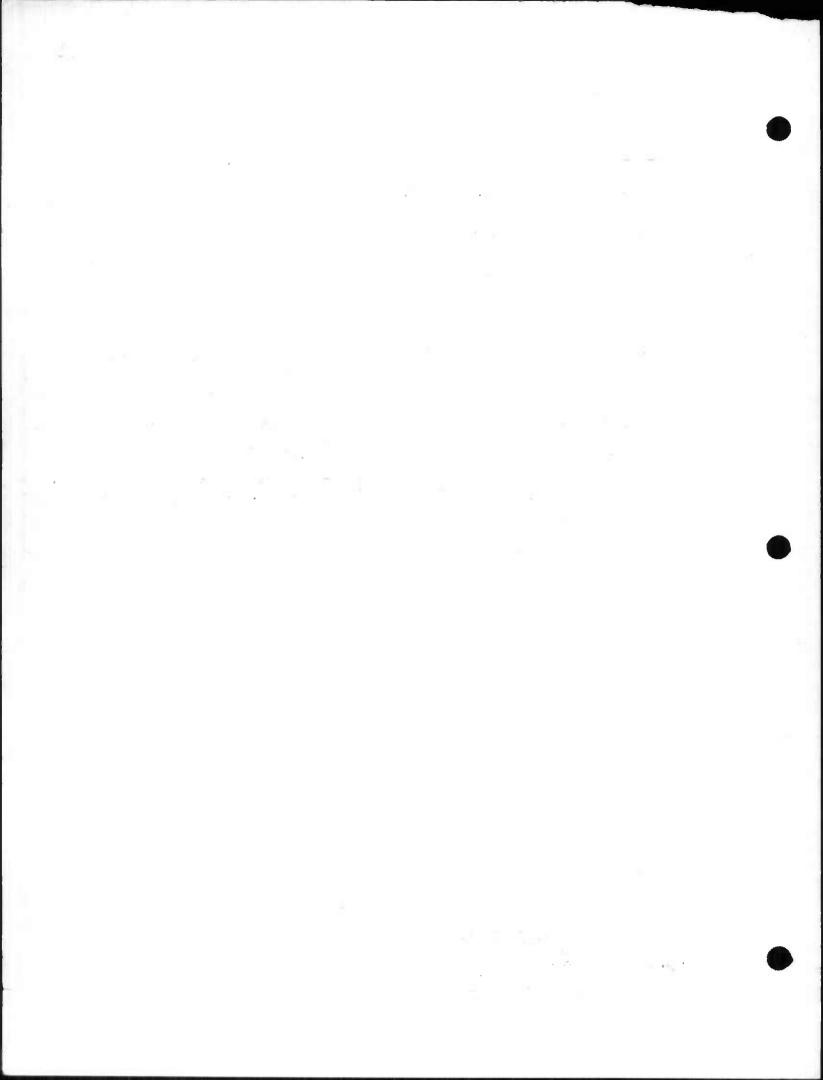
IC. S. RAO. M. D. MESTHWEST HOSPITAL

RANDALLSTOWN M. CENTER CILA A REGISTRATE SIGNATURE LA 31. DATE FILED (Month, Day, Year) NOV 09 1995

an.	transit permit, Pages 1, 2, 3 should		
PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, Page 6 may be retained by the hospital or attending physician.	rificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit, Pages 1, 2, 3 should		otified at once.
hin 24 hours after death. Page 6 may be n	tely filled in by the funeral director, page 5	mation, or removal,	ed, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
hat the death certificate be executed with	by the attending physician and complete	rith the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal,	ny Injury, or other traumatic event
IDING PHYSICIAN: The law requires th	: After this certificate has been signed	23	is marked, or item 23 shows an
TO THE HOSPITAL OR ATTENDING PHY	TO THE FUNERAL DIRECTOR; After this certif	be filed within 72 hours after death with	IMPORTANT: If item 28 is marked,

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL	HYGIENE
CERTIFICATE OF DEATH	REG. NO.

	FOR STATE REGISTRAR	STATE OF MARYLAN	D / DEPART				YGIENE EG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last) Margaret Rita	Wychulis				2. DATE OF D	er 31,199	YEAR	3. TIME OF DEAT	
			s. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF B			9:55	Рм
	186-16-5237	1 M 2 XXF 80	YRS.	ONTHS DAYS	HOURS MIN.	Oct.	28,1915	Pen	nsylvan	
DIRECTOR	90. FACILITY NAME (If not institution, give street Johns Hopkins Baresidence of Decement				more Cit			TY OF DE	ATH	
EG.	10e. STATE 10b. COUNTY		10c. CITY,	TOWN OR LOCAT	TION				10d, INSIDE CITY	,
DIR.	Maryland 100. STREET AND NUMBER	Baltimore			ndalk				LIMITS?	(NO
FUNERAL				101	. ZIP CODE				HAT COUNTRY?	
N.	3423 Cowrt Way	12. WAS DECEDENT EVER IN U.S	S ADMED	12 WMS DEC	21222 ENDENT OF HISPAI				tates	
	1 Never Married 2 Merried	FORCES? 1 YES 2	ONE	If yee, sp	ecify Cuben, Mexics	n, Puerto Rican		Black, Specify	White, atc.	en,
ВҰ	3 Widowed 4 Divorced	IF TES, GIVE WAR ON DATE:	•	T TES	ZX NO Specif	у:		эреспу	White	
COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade of	ATION 18-	e. DECEDENT'S U	SUAL OCCUPATION	ON set of working	16b. KIN	D OF BUSINESS/IND	JSTRY		
	Elementary/Secondery (0-12)	College (1-4 or 5+)	life. Do NOT use	retired.)	or or or or or or or or or or or or or o					
MP	12 Years		Superv.	isor			Coat Manu	fact	uring	
	17. FATNER'S NAME (First, Middle, Last)	Mariahati'			18. MOTNER'S NA	_, .,	e, Meiden Surname)			
BE	NOT KNOWN 194. INFORMANT'S NAME (Type/Print)	Novickski	-				Known			
2		,					City or Town, State, Zip			
	Margaret Rita Ray		ACEAND DATE OF		Crest Mc		20c. LOCATION — (360	- 0	
	1 Buriel 2X XCremetion 3 Remov	rel from Stete	matory or othe	er place)	atio 11/	7/100E	Towson	ity or low	to a Dana	
	21. SIGNATURE OF FINERAL SERVICE LICE	NSEE	() 30	22. NAME AF	ND ADDRESS OF FA	CILITY				
	Man	8/1/2	>				tome of D			
_	- Vaga	E VCOOL					ndalk, MD			
	23. PART I. Enter the distance, or co shock, or feart failure.	t only one ceuse on each	a daath. Do no iline,	t enter the mo	de of dying, suc	th ae cardiac	or reapiratory arm	rat,	Approxim interval B	etween
	iMMEDIATE CAUSE (Final disease or condition								Onset and	
	resulting in death) e	Myocardial In							12 h	ours
_	-		,						ĺ	
2	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A CO	NSEQUENCE OF):							
S	cause, Enter UNDERLYING CAUSE (Disease or Injury									
CERTIFICATION	that initieted events	DUE TO (OR AS A CO	INSEQUENCE OF):							
ER	resulting in death) LAST									
AL C	PART II. Other aignificent conditions	contributing to death but	not resulting in	the underlyin	g cause given in	Part I. 24a	. WAS AN AUTOPSY	24b.	WERE AUTOPSY F	INDINGS
2	Diabetes mellit	us					PERFORMED?		AMILABLE PRIOR COMPLETION OF	
						_ '	TES ZINO	- 1	OF DEATH?	NO.
PHYSICIAN: MEDIC	DID TOBACCO USE CONTR	IBUTE TO CAUSE OF I	DEATH YES	□ NO □	UNCERTAI	N 🛭			, Lo TA	
IA	25. WAS CASE REFERRED TO MEDICAL		PLACE OF DEATH	(Check only one)		1.00				
SIC		HOSPITAL: 1 1 Inpatient 2 ER/Outpatie		OTHER:	ne 5 🗆 Residence	8 Other (Sp	ecity)			
£	27. MANNER OF DEATN	25e. DATE OF INJURY (Month, Day, Year)	28b. TIME INJU		JURY AT	28d. DESCRIE	BE NOW INJURY OCC	URED		
BY	1 X Natural 5 Pending 2 Accident Investigation				YES 2 NO					
COMPLETED	3 Suicide S Could not be determined	28e. PLACE OF INJURY — building, etc. (Specify)	At home, term, str	eet, lectory, offic	:0		N (Street end Number wn, Stete)	or Rural Ro	oute Number,	
	29e. CERTIFIER		4 4							
Z. Z	and any	IAN: To the best of my knowledge: On the bests of examination en							and manner ea s	stated
	29b, SIGNATURE AND TITLE OF CERTIFIER			,,,						
BE	DA A A D O O	to us and it			29c. LICENSE NU	00			(Month, Day, Year) er 1,199	
2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEATN	(ITEM 27) (Type I	Print)	M69					
				Johns 4940	Hopkins Eastern	s Bayvi Avenue	ew Medica , Baltim	al Ce ore,	enter MD 21	224
	NOV 0 9 1995	32 REGISTRAR'S GNATU	K							



COMPLETED

96

2

Pages 1, 2, 3 should use as the burial-transit permit. ğ detached once. page 5 should be H notified hours after death. Page 6 may be pe must director, examiner the medical in by filled the cremation, pletely event, bunal, traumatic and certificate be other 1 the attending p 0 requires that the death Injury. any Health a shows c. of F has be OR ATTENDING PHYSICIAN: The law 23 tem certificate to the State 1, or Item this c. marked, After 10 DIRECTOR: A hours after d Item 28 Is lem FUNERAL C within 72 h HOSPITAL TO THE HOSPITA
TO THE FUNERAL
De filed within 72
IMPORTANT: II

95 33880 ITEM: 4. PER PERSONAL REP. FILM G-730 12/4/95 t.t STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH BEG NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH YEAR GRACE 1995 12:50 P M MARION WILLIAMS Nov. 4. SOCIAL SECURITY NUMBER 5. SEX 7. DATE OF BIRTH (Month, Day, Year) 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR 8. BIRTHPLACE (State or Foreign IF UNDER 24 HRS. DAYS 1 🗌 M 2 🎽 F 215-05-9084-9844 91 Aug. 9, 1904 Ohio 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Manor Care Towson Towson Baltimore 10b. COUNTY 10c, CITY, TOWN OR LOCATION 10e. STATE 10d. INSIDE CITY Md. Baltimore Rodgers Forge 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 10L ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 237-B Rodgers Forge Rd. 21212 U.S.A. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuben, Mexicen, Puerto Ricen, etc.)
1 □ YES 2 ☑ NO Specify: 12. WAS DECEDENT EVER IN U.S. ARMED 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2 NO 1 Never Merried 2 Merried Specify: ВҮ 3 Widowed 4 Divorced White ETED. 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION Mercantile Safe Deposit & (Specify only highes (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) COMPL 4 Real Estate Trust Co. 17. FATNER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Meiden Surname) William . Williams Henry Jennie 8 Hughes 19e. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 John B. Williams 4800 Arabia Ave. Hamilton, Md. 21214 20a, METNOO OF OISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION - City or Town, State Burial 2 Cremation 3 Removal from State Parkwood Cemetery 11/9/95 Parkville, Md. MATURE OF FUNERAL GERVICE LICENTEE 22. NAME AND AGORESS OF FACILITY Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata ahock, or haart failure. List only one cause on each line. Interval Batween Onset and Death IMMEDIATE CAUSE (Final disease or condition ACUTE RESPIRATORY FAILURE 1 hour resulting in death) DUE TO (OR AS A CONSEQUENCE OF): Restrictive Lung Disease 2 weeks CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Entar UNDERLYING 30 years Kyphoscoliosis of Thoracic Spine CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events reaulting in death) LAST PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24e. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS MEDICAL **AMILABLE PRIOR TO** COMPLETION OF CAUSE 1 ☐ YES 2 🙀 NO OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN 🖾 PHYSICIAN: 26. PLACE OF OEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL EXAMINER?

1 YES 2 X NO HOSPITAL: OTHER:
4X Nursing Nome 5 - Residence 8 - Other (Specify) 1 | Inpatient 2 | ER/Outpetient 3 | DOA 27. MANNER OF DEATN 28a. OATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 X Natural 5 Pending 1 YES 2 NO BY

Investigation 2 Accident 28e. PLACE OF INJURY — At home, term, street, tectory, office building, etc. (Specify) 281, LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide 8 Could not be determined 29a. CERTIFIER

Thank and

To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end manner es stated. 2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occured at the time, date end piece, and due to the cause(s) and menner as stated.

29c LICENSE NUMBER

341

De mi 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

John Milto, M.D. 7600 Osler Dr. Towson, Md. 21204

32 REGISTRAR'S SIGNATURE

29b. SIGNATURE AND TITLE OF CENTER

29d. DATE SIGNED (Month, De

asp

TO BE COMPLETED BY FUNERAL DIRECTOR

1 - FOR STATE REGISTRAR	STATE OF MARYLAN	D / DEPARTM CERTIFIC			MENTAL HYGIEN	_			
1. DECEDENT'S NAME (First, Middle, Last	1)				2. DATE OF DEATN	-	3. 7	TIME OF OEATN	
ELIES WHITE J	JR.				OCTOBER "	29 19	755	1:23 P M	
4. SOCIAL SECURITY NUMBER		s. lest birthday)IF	UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTN	1	. BIRTNPLA	CE (State or Foreign	
214-50-4880 9a. FACILITY NAME (If not institution, give	1x2 M 2 □ F 48	YRS.	HTHS DAYS	HOURS MIN.	(Month, Day, Year) 9/26/19	-		., MD	
300 BLK DOLI		96		MORE C		9c. COUNT	Y OF DEATH		
RESIDENCE OF DECEDENT	TITIN SI.		DALII	IMORE C	T 1 1		N/A	(=	
10a. STATE 10b. COUN	ITY	18c. CITY, T	OWN OR LOCAT	ION			10d	. INSIGE CITY	
MARYLAND 10e, STREET AND NUMBER	N/A	В	ALTIMO					LIMITS? YES 2 NO	
549 W. LAFAYE	TOD AMDAMID		101	ZIP CODE		10g. CITIZE	EN OF WHAT	COUNTRY?	
				21217		1	USA		
11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT EVER IN U. FORCES? 1 YES 2	NO			HC ORIGIN? (Specify Yan, Puerto Rican, etc.)	a or No- 1	4. RACE — A Black, Wh	American Indian, illa, etc.	
3 Widowed 4 Divorced	IF YES, GIVE WAR OR DATE	3	1 TYES	23 NO Specifi	<i>y</i>		Specify:	Black	
15. DECEDENT'S ED (Specify only highest gra	DUCATION 18 de completed)	 DECEDENT'S USI (Give kind of work) 	done during mo		16b. KIND OF BL	SINESS/INDU	STRY		
Elementary/Secondary (0-12) 12th	College (1-4 or 5 +)	Super			Soci	al Se	curi	ty	
17. FATNER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Middle, Maider	n Surname)			
ELIAS WHITE, SR. ANNIE ROSS									
19a, INFORMANT'S NAME (Type/Print)	70.V				Route Number, City or Tox				
ESTHER MIDDLET								MD 21217	
20a. METNOD OF DISPOSITION 1 □ Burlal 2 □ Cremetion 3 □ Re 4 □ Donation	movel from State cemeter	ACE AND DATE OF E ry, crematory or other odlawn	plece!		1.	1 + 1 mo		aryland	
21. SIGNATURE OF PUNERAL SERVICE		111	22. NAME AN	ID ADDRESS OF FA	CILITY				
EXTROU	O. Du	tt	4600	LIBERT	ETT & SO Y HEIGHT	N FUN S AVE	ERAL	HOME 21207	
23. MB I. Steer the disease of the court in	a. ATHEROSCLEROTI	C CARDIOVA			h aa cerdiac or resp	oiratory arre	B\$,	Approximate interval Batween Onsat and Daath	
Sequentially list conditions, if any, leading to immediate	b DUE TO (OR AS A CO	INSEQUENCE OF):							
cause. Enter UNDERLYING CAUSE (Disease or Injury	C								
that initiated events reaulting in death) LAST	DUE TO (OR AS A CO	INSEQUENCE OF):							
Total Ling III document of the Control	d								
PART II. Other algnificant condition	DNA CONTRIBUTING to death but	not reaulting in t	the underlyin	g cause given in		RMED?	COR	RE AUTOPSY FINDINGS ILLABLE PRIOR TO MPLETION OF CAUSE DEATH? S 2 \(\text{NO} \) NO	
DID TOBACCO USE CON	ITRIBUTE TO CAUSE OF	DEATH YES	□ NO □	UNCERTAI	NU				
25. WAS CASE REFERRED TO MEDICAL		PLACE OF DEATN							
EXAMINER? 1 √ YES 2 □ NO	HOSPITAL: 1 Inpatient 2 ER/Outpatie	unt 3 7 004 4	THER:	o 6 🗆 Booldonso	all Other County				
27. MANNER OF DEATN	28a. DATE OF INJURY	28b. TIME C			8X Other (Specify) 28d. DESCRIBE NOW				
1XX Natural S. Frending	(Month, Day, Year)	RULNI		YES 2 NO					
2 Accident Mivestigation 3 Suicide 8 Could not b 4 Nomicide determined	28e. PLACE OF INJURY — building, etc. (Specify)	At home, ferm, atre	et, fectory, offic	4	281. LOCATION (Street City or Town, State	t and Number o	r Rural Route	Number,	
20. CERTIFIER									
(Check only	YSICIAN: To the best of my knowled NER: On the bests of examination a							d manner as stated.	
296. SIGNATURE AND TITLE OF CERTIF	TIER 1 2 -			29c. LICENSE NU	MBER	29d. DATE	SIGNED (Mo	rith, Day, Year)	
Num	& Clinta			O.C.M.1	E	DCT	OBER	29,1995	
30. NAME AND ADDRESS OF PERSON	NHO COMPLETED CAUSE OF DEATH	TT1"Pei	nn Str						

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DENAILS CHUTE
31. DATE FILED (Month, Day, Your)

NOV 0 9 1995

Land it was a second

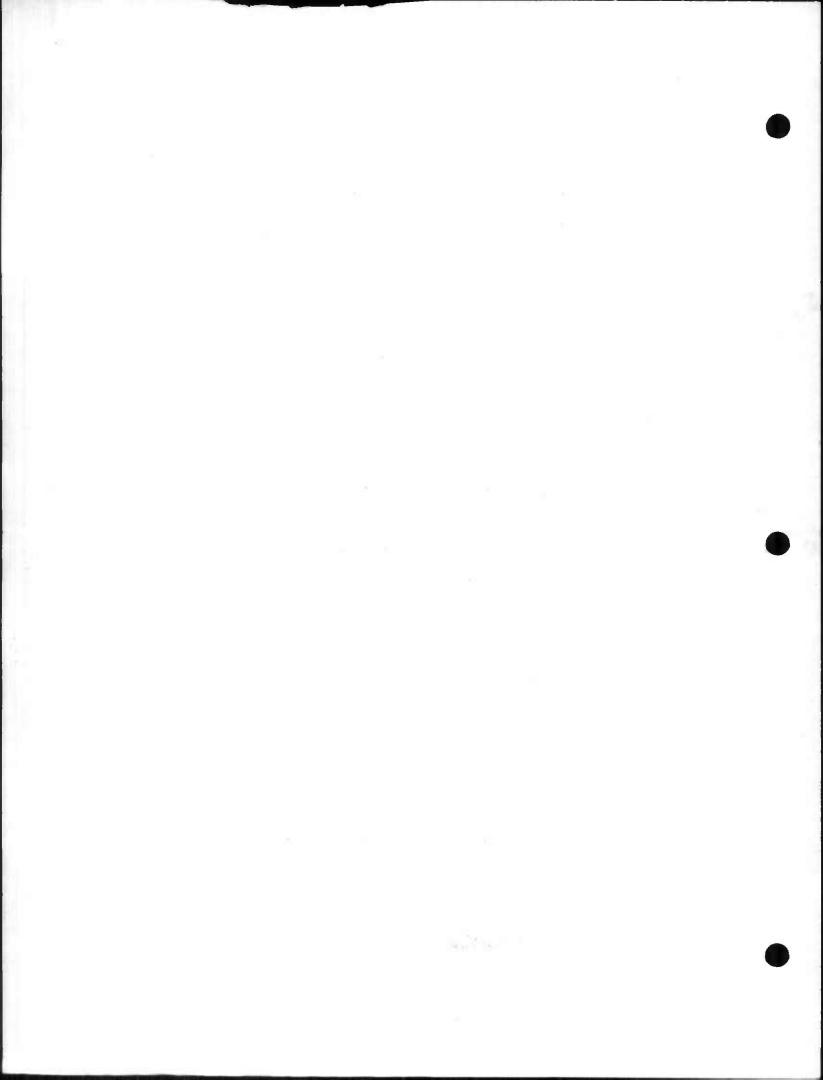
BALTIMORE, MARYLAND 21215-0020

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IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	FOR 1 - STATE REGISTRAR	STATE OF MARYLA	ND / DEPARTM			MENTAL	HYGIENI REG. NO.	E			
	1. DECEDENT'S NAME (First, Middle, Lest)					2. DATE O	F DEATH			3. TIME OF DEATH	
	LEONARD AZRE	LL ZIFF				MONTH	EMBER	6, 199	EAR	7:09pm M	
	4. SOCIAL SECURITY NUMBER 5	SEX 6. AGE (In		UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE O	F BIRTH	0.	BIRTHP	LACE (State or Foreign	
	213-98-6714 1		72 YRS.	NTHS DAYS	HOURS MIN.	AUG.	Day: Year)	1923 M		TLAND	
DIRECTOR	NORTHWEST HOSPITAL		31		LLSTOWN	AIR		9c. COUNTY OF CEATH BALTIMORE			
딥	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY		10c. CITY. T	OWN OR LOCAT	ON			10d. INSIDE CITY			
E	MADVE AND DA	I MIMODD							- 1	LIMITS?	
	MARYLAND BATTON 100. STREET AND NUMBER	LTIMORE		101.	RALTT ZIP CODE	MORE		10g, CITIZEN		HAT COUNTRY?	
FUNERAL	33 HEATHERTON COUR	f r			21244			US	A		
S		2. WAS DECEDENT EVER IN			ENDENT OF HISPAN			or No — 14.	RACE	- American Indian,	
BY F	1 Never Merried 2 Merried 3 Wildowed 4 Divorced	FORCES? 1 YES	TESX		cify Cuban, Mexice 2 NO Specify		cen, etc.)		Specify	White, etc.	
	1			1						WHITE	
COMPLETED	15. DECEDENT'S EDUCAT (Specify only highest grade co	(ION mpleted)	(Give kind of work life. Do NOT use n	done during mo:	N at of working	16b.	KIND OF BUS	INESS/INDUS	FRY		
E	Elementary/Secondary (0-12)	College (1-4 or 5+)	PACKA			3.4.7	א מוד זוא	TURING			
ME	17. FATHER'S NAME (First, Middle, Last)		I ACIO	JOLIN	16. MOTHER'S NA				,		
	ISADORE	ZIFF			SARAH		IGGIB, MIBIGBII :	CARF	,		
BE	19e. INFORMANT'S NAME (Type/Print)	2111	19b. MAILING AC	ORESS (Street a	nd Number or Rural I		er City or Town			21228	
2	TOM NOTO c/o LIFE	INC.			RE NATIO					LE, MD	
	20e, METHOD OF DISPOSITION	20b.	PLACE AND DATE OF			DATE	-	CATION - City			
	1 XBurial 2 Cremetion 3 Remove 4 Donation 6 Other (Specify)		ALTIMORE"			11-8-		BALTIM			
	21. SIGNATURE OF FUNERAL SERVICE LICEN	ISEE		22. NAME AN	D ADDRESS DF FA	CILITY					
	b by /1/6	Olici			EVINSON						
	23. PART/I. Enter/the diseases, or cor	notications that caused	the death Do not							, MD 21215	
	shock, or heart fellure. Lis	at only one ceuse on ea	ch line.	enter the mo	ue or cymg, suc	en de Cardi	ac or reapi	ratory arrea	9	Approximate interval Between	
	IMMEDIATE CAUSE (Finel disease or condition	D	Mal	. 0 -	1-0	1	221	1210	~	Onset and Death	
	resulting in death) a	DUE TO (OR AS A	CONSEQUENCE OF:	010	1000	-	10 11		Sp.	2 1000	
_		12 67	o mis	. 0	dial onl	110	2	1		1 Vyn	
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A	CONSEQUENCE OF):		4-1-	.01					
SAT	couse. Enter UNDERLYING										
Ĕ	CAUSE (Disease or injury that initiated evants	DUE TO (OR AS A	CONSEQUENCE OF):								
EBI	reaulting in deeth) LAST										
	PART II. Other algolificent conditions	contributing to deeth be	ut not resulting in	the underlying	cause given in	Part I.	24s. WAS AN	AUTOPSY	24b.	WERE AUTOPSY FINDINGS	
CAL	Reducad	M 4614	100e	che	, g		PERFOR	MED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE	
	1.032.030		(0)			-	1 YES 2	NO		OF DEATH?	
PHYSICIAN: MEDIC	DID TOBACCO USE CONTRI	BUTE TO CAUSE O	F DEATH YES	I NO I	UNCERTAI	NΠ				1 YES 2 NO	
NA	25. WAS CASE REFERRED TO MEDICAL		26. PLACE DF DEATH		OT TOLKT						
SIC		HOSPITAL:		THER:	e 5 🗆 Raeldence	8 Other	(Specify)				
H	27. MANNER OF DEATH	28s. DATE OF INJURY	28b. TIME (OF 28c. INJ	URY AT			NJURY OCCUP	RED		
	1 Netural 5 Pending	(Month, Day, Year)	INJUR		RK? (ES 2 NO						
) BY	2 Accident Investigation 3 Suicide 6 Could not be	26e. PLACE OF INJURY building, atc. (Spec	— At home, ferm, stre	et, factory, offic				and Number or	Rural A	oute Number,	
三	4 Homicide determined	bunding, atc. (Spec	ny)			City o	r Town, State)				
COMPLETED	29a. CERTIFIER 1 CERTIFYING PHYSICI	AN: To the best of my knowl	edge, death occurred	at the time, date	and place, and due	to the caus	se(e) end mer	yner as stated			
ME	onel only	On the basis of exemination							:0050(8)	end menner ee stated.	
	29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUI	MBER		29d. DATE S	IGNED	(Month, Day, Year)	
BE	D. Q. A. B. 1	Kurin	n. h	W	0187	77		> \	11	7159	
2	30. NAME AND ADDRESS OF PERSON WHO				-	3 /		,	11		
	DR. ROBERT KROOPNIC	CK 8620 LIBE	RTY ROAD	RANDALI	STOWN, MI	D 211	33				
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGN									
	NOV 0 9 1995 July	in Develor lan	LA								



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FOR STATE REGISTRAR

STATE	OF I	MARYL	AND /	DEPAR	TMENT	0F	HEALTH	AND	MENTAL	HYGIENI	Ε
			CI	ERTIF	ICATE	O	F DEAT	ГН		REG. NO.	

	1. DECEDENT'S NAME (First	, Midalle, Last)								2. DATE OF DEATN			3. TIME OF DEATN
	ALICE	VIOL	A ANDE	RSON					k	October	5,19	95"	8:10 Am
DIRECTOR	4. SOCIAL SECURITY NUME	BER	5. SEX	6. AGE (In yrs. las	t birthday)	IF UNDER	t YEAR	IF UNDER	_	7. DATE OF BIRTH		8. BIRTH	IPLACE (State or Foreign
	080-32-	1066	1 M 2 N	88	YRS.	MONTHS	DAYS	HOURS	MIN.	(Month, Day, Year)	12 1	906	nv)
	Sa. FACILITY NAME (If not in		reet and number)			9b. CITY	TOWN	OR LOCATION	ON OF DEA			INTY OF D	
5	Magnolia 1	Hall 1	Nursing	Home								Cent	
8	RESIDENCE OF DEC		Har Dang	Home	Offester down							enc	
H	10a. STATE	10b. COUNTY	,		10c. CIT	Y, TOWN C	R LOCA	TION					10d. INSIDE CITY LIMITS?
	MD	Que	en Ann	es	C	hes	ter	town	L				1 YES 2 NO
4	10e. STREET AND NUMBER						10	f. ZIP CODE	E		10g. CIT	IZEN OF V	WHAT COUNTRY?
FUNERAL	244 R:	iver	Road					216	20			U.S	. A .
5	11. MARITAL STATUS		12. WAS DECEDEN	T EVER IN U.S. AR	MED	13.	WAS DEC	ENDENT O	F HISPANI	C ORIGIN? (Specify Yes	or No-	14. RACE	E — American Indian.
BYF	1 Never Married 2		IF YES, GIVE V	YES 2 X	Ю		f yes, sp	2 NO	n, Maxican, Specify:	, Puerto Rican, etc.)		Speci	k, Whife, etc.
	3 Widowed 4 Divo	rced		3.00				30					White
E I	15. DEC (Specify only	EDENT'S EDUC y highest grade	CATION completed)	16a, DE	CEDENT'S	USUAL O	CCUPATH	ON est of workin	in .	166, KIND OF BU	SINESS/INI	DUSTRY	
<u> </u>	Elementary/Secondary (0	1-12)	College (1-4 or 5	+) life.	Do NOT us	se retired.)			_				
A P	9		No	Me	edic	al	Sec:	reta	ry		Med	ldca.	1
COMPLETED	17. FATNER'S NAME (First, M.	,								E (First, Middle, Maiden	Surneme)		
BE	Peter	Danie	el Tie	demann				E	va	Hanna	Good	lacre	e
0	19a. INFORMANT'S NAME (7)									oute Number, City or Tow			
- 1	on isome Oldin Fabon 244 River Road, Chestertown, MD									MD 21620			
20s. METHOD QE DISPOSITION 1 Greenation 3 Greenation 3 Greenation State 20s. PLACE AND DATE of DISPOSITION (Name of Compalery, Creenatory of Disposition of Compalery, Creenatory of Capitol Crematory 10/6/95 Dover, I									wn, State				
1	21. SIGNATURE OF FUNERAL	L SERVICE LIC	ENSE			22. M:	NAME A	D ADDRES	S OF FACE	Villiams	Tra	2.	1620
]	> War	2 Vil	Willia	1		F	717	TII V	TATO T T	Ls FH, Cl	ort.	ont	orm MD
	23. PART I. Unter the di	sesses, Dr C	omplications the	t caused the de	eth. Do r	not enter	the mo	de of du	Me TI	es cardiac or read	retory or	61.00	Approximate
	snock, or ne	eart fellure, L	List only one cau	se on each line									Interval Between
- 1	iMMEDIATE CAUSE (Fin disease or condition	inf	(1		6,00	1	- ml		1	1			Onset and Death
H	resulting in death)	7	DUE TO	OR AS A CONSEC	I POC O	1 4	000		Jaco	Mre			6 mmsts
_			JOE 10	I was a consec	< C	2.4		Pun.	1.	luxe ascular	D		1060012
CERTIFICATION	Sequentially list conditi			(DR AS A CONSE				0 6		40000 201	11	2000	6 10 10 3
X	If any, leading to immed cause. Enter UNDERLY	NG				•							İ
Ĕ	CAUSE (Disease or Inju- that initiated events	ry 🄰 °	DUE TO	(DR AS A CONSE	UENCE OF	F):							
토	resulting in death) LAS	т [_	le .										
2	0107 11 015 11 111												
MEDICAL	PART II. Other algnifica	nt conditions	contributing to	death but not r	sulting l	In the un	derlying	g cause g	iven in P	art I. 24s. WAS AN PERFOR		24b.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO
ă)								1 YES 2	The		COMPLETION OF CAUSE DF DEATH?
뮕													1 YES 2 NO
ä													
§ I	25. WAS CASE REFERRED TO EXAMINER?	MEDICAL	HOSPITAL:					ACE OF D	EATH (Chec	k only one)			
S	1 YES 2 HO		1 Inpatient 2	ER/Outpatient 3	□ DOA	OTHER		e 5 🗆 Re	sidenca 8	Other (Specify)			
PHYSICIAN:	27. MANNER OF DEATH		28a. DATE DF (Month, D		28b. TIM	E OF URY	28c. INJ	URY AT		28d, DESCRIBE NOW II	NJURY OC	CURED	
BY		Pending investigation				М		rES 2] ND				
	3 Suicide 6 🗌	Could not be	28a. PLACE O	F INJURY — At ho atc. (Specify)	ne, ferm, I	Street, facto	ory, offic			261. LOCATION (Street a	nd Number	or Rural A	Toute Number,
H I	4 Nomicide	determined		,					_	City or Town, State)			
2	29a. CERTIFIER 1 CERT	IFYING PNYSIC	IAN. To the best of	my knowledge, de	eth occum	ed at the ti	me, data	and place.	and due to	the cause(e) end men	ner as stat	ted.	
COMPLETED) end menner se stated.
	29b. SIGNATURE AND JUTLE		11/	7	-	-			NSE NUMB				
띪	51	Sin	11	my m	D			7)/1	703	6-M1	Z9G. DAI	10/6	(Month, Day, Year)
2	30. NAME AND ADDRESS OF		COMPLETED CAUS	E DE DEATH (ITEM	27) /Tvne	Print)		011	-	, , ,	-	- 101	
	Sus AN	K. 1	2055 m	P 516	W	168h	ing,	to	Are.	Chestra	tone	Md	21620
	31. DATE FILED (Month, Day,	0 '95	32. REGISTIN	his signature	n-Aan	dell	J						

BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE RUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be neitfied at once.

	1 - FOR STATE OF MARYLA REGISTRAR	ND / DEPARTM CERTIFIC	MENT OF H	EALTH AND M	IENTAL HYGIEN		
	1. DECEDENT'S NAME (First, Middle, Last) JOHN LEE ADAM	IS .			2. DATE OF DEATH DOCTOBER 30		3. TIME OF DEATH 0300 M
	216-40-4407 ØŒM2□F 51	YRS. MO	FUNDER 1 YEAR ONTHE DAYS	IF UNDER 24 HRS. HOURS MIN.	Feb. 8 19	944 Mar	HPLACE (State or Foreign by) yland
TOR	90. FACILITY NAME (If not institution, give street end number) 903 Central Ave. RESIDENCE OF DECEDENT	96		mbridge	ТН	Dorche	
DIRECTOR	Maryland Dorchester	10c. CITY, TO	Cam	bridge			10d. INSIDE CITY LIMITS? 1 XXYES 2 NO
FUNERAL	903 Central Ave.			ZIP CODE 2161		U.S.A	
BY	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced 12. WAS DECEDENT EVER IN (FORCES? 1 YES IF YES, GIVE WAR OR DAT	2 X NO	II yes, spe	endent of Hispanic city Cuben, Mexican, 2 X NO Specify:	C ORIGIN? (Specify Yes , Puerto Rican, etc.)	Black	E — American Indian, k, White, etc. #/y: White
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	16a. DECEDENT'S USU (Give kind of work life. Do NOT use re Carpent	done during mos stired.)	N at of working		employed	
BE COM	17. FATHER'S NAME (First, Middle, Lest) John Levin Adams	1			E (First, Middle, Meiden		
TO B	190. INFORMANT'S NAME (TypoPrint) James L. Adams	P.O. Bo	DRESS (Street and	Vienna M	0° 21869° Town	n, Stete, Zip Code)	
	1 Buriel 2 & Cremetion 3 Removal from State 4 Donation 8 Other (Specify)	PLACE AND DATE OF D leav, cremetory or other, LLISDURY	Cremato	ry	Sal	cation — city or to Lisbury M	
	21. SIGNATURE OF PAREAL SERVICE LICENSEE		Thoma 700 L	s Funeral ocust St.	l Home . Cambridg	ge MD 216	513
	23. PART I. Enter the disesses, or complications that caused to shock, or heart failure. List only one cause on asc IMMEDIATE CAUSE (Final disesse or condition resulting in death) DUE TO (OR AS A C	PDIAL				retory srrest,	Approximate interval Between Onset and Death
CERTIFICATION	Sequentisity list conditions, If any, isading to immediate	POSCLE CONSEDUENCE OF): (E) (E)	7205VJ				YPS 4125
AL	PART II. Other algorificant conditions contributing to death but	not resulting in the	he undarlying	cause given in Pr	ert I. 24e. WAS AN PERFOR	MED?). WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 ND
PHYSICIAN: MEDIC	DID TOBACCO USE CONTRIBUTE TO CAUSE OF 25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL:	. PLACE OF DEATH (C		UNCERTAIN			10,100 20,110
	1 YES 2 NO 1 Inpetiant 2 ER/Outpett 27. MANNER OF PEATH 28e. DATE DF INJURY (Morith, Day, Year)		F 28c, INJU WOR	FRESIDENCE 8	Other (Specify) 28d. DESCRIBE HOW IN	JURY OCCURED	
TED BY	2 Accident Investigation 3 Suicide 8 Could not be detarmined 28e. PLACE OF INJURY – building, stc. (Specify,	At home, term, stree			281, LOCATION (Street a City or Town, State)	nd Number or Rural F	Route Number,
COMPLETED	29s. CERTIFIER (Check only one) 1 LEERTIFYING PHYSICIAN: To the best of my knowled one) 2 MEDICAL EXAMINER: On the basic of examination a						e) end menner ee stated.
TO BE	29b. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH	1		29c. LICENSE NUMB	73	≥ 1073	(Month, Day, Year)
	31. DATE FILEDING VON 1 1995	15	503	BYRIN	57 C	AMBRIO	46 MD
	7101 01 1000	readally					

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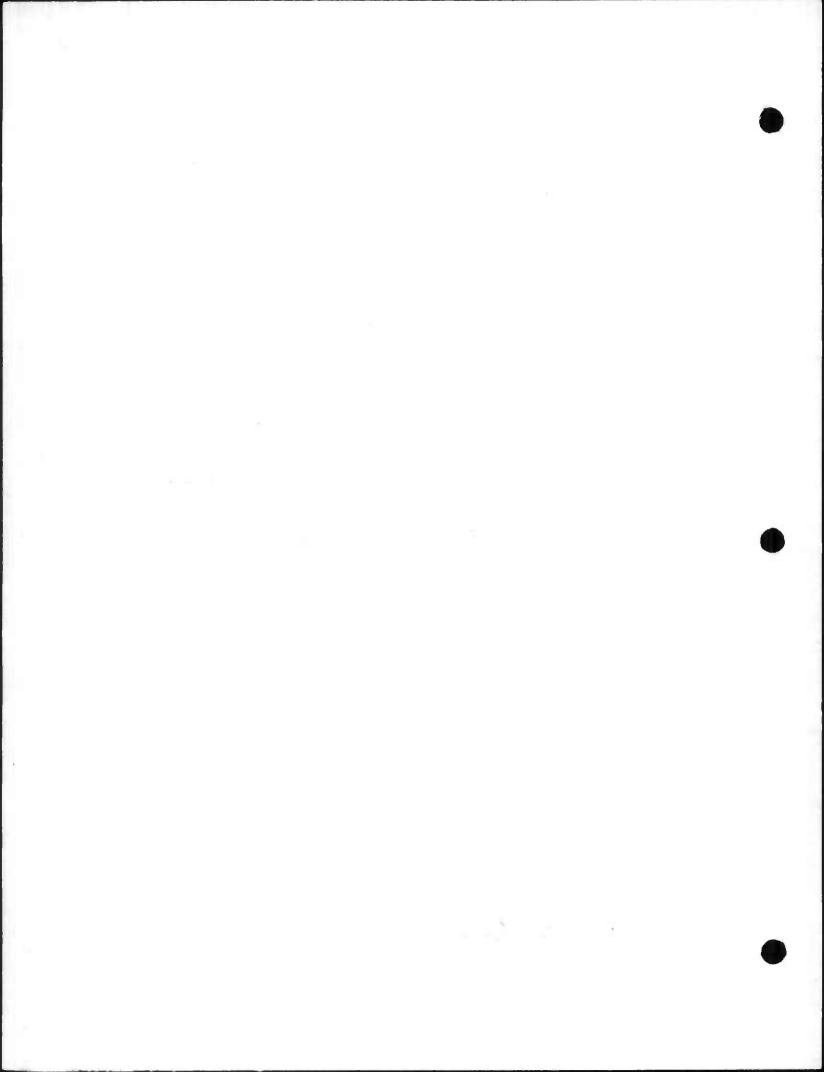
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR 1 STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CE	RTIF	ICATE C	F DEATH		REG. NO				
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE C	OF DEATH			3. TIME OF DEATH	
	CIARA	RAYE	ABBOTT				OCT	25	10	995	10:20 P M	
1 8	4. SOCIAL SECURITY NUMBER	5, \$EX	6. AGE (In yrs. last	hirthday)	IF UNDER 1 YEA	IF UNDER 24 HRS.	7. DATE O				PLACE (State or Foreign	
		1 □ M → □ F		YRS.	MONTHS DAY		(Month,	Day, Year)		Country	1)	
	9s. FACILITY NAME (If not institution, give			71101	0 3			23,	1995 Maryland			
~				9b. CITY, TOWN OR LOCATION OF DEATH						INTY OF DE	EATH	
Ö	University of Md	. Hospital				Baltimore			E	Baltir	nore City	
DIRECTOR	RESIDENCE OF DECEDENT 10a, STATE 10b, COUN											
2					r, TOWN OR LO					1.	10d. INSIDE CITY	
		roline		F	edera1	sburg				[2	YY LIMITS?	
A	10e. STREET AND NUMBER					10f, ZIP CODE			10g. CIT	IZEN OF W	HAT COUNTRY?	
E	3460 Laurel Grov	e Road				21632				US		
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT	EVER IN U.S. ARI	MED	13 WAS	DECENDENT OF HISPA	NIC ODICINA	(Paralle Mar	as No	44 0405	American American	
	1X Never Married 2 Married	FORCES? 1	YES 2 X N	0	If yes	specify Cuban, Mexic	an, Puerto Ri	can, etc.)	or No -	Black,	- American Indian, White, etc.	
B	3 Widowed 4 Divorced	IF YES, GIVE W	AR OR DATES		10	YES A NO Speci	y:			Specify	y: White	
	16. DECEDENT'S ED	LICATION	140 050	COCNIZIO	HOUSE COOKIN							
1	(Specify only highest grad	te completed)	(Gh	ve kind of v Do NOT us	USUAL OCCUP	most of working	16b.	KIND OF BU	SINESS/IN	DUSTRY		
1 2	Elementary/Secondary (0-12)	College (1-4 or 5 +	170.	N/A	e retired.)							
Σ				N/A								
COMPLETED	17. FATHER'S NAME (First, Middle, Lest) Kurt O'Brien	Cummir	0.00			18. MOTHER'S NA	AME (First, Mi	ddle, Maiden	Sumeme)			
BE	Rule o Bilen	Cummin	igs			Tiffa	ni Dav	vn Abb	oott			
	19a, INFORMANT'S NAME (Type/Print)		19b	MAILING	ADDRESS (Stre	et and Number or Rural	Route Numbe	r, City or Tow	n, State, Zi	p Code)		
5	Tiffani Dawn Abb	ott									21632	
	The state of the s											
	20s. METHOD OF DISPOSITION 1X Burlel 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) 20c. LOCATION — City or Town, State 20c. LOCATION — City or Town, State 10/29 East New Market,										*	
	21. SIGNATURE OF PUNERAL SERVICE L		LEAST N	ew M				Las	st Ne	w Mai	rket, Md.	
1 1	21. SIGNATURE OF FUNERAL SERVICE L	CENSEE	-			as Funera		D /				
	1) grenelle 1	8. Ihan	- 9		700	Locust St	Comb	ridae	Mo	1	J 21612	
	23. PART I. Enter the diseases, or	complications that	and the state	al D-	1700	LOCUST ST	· Callin	or rage	, ma	тутаг		
	ahock, or heart fellure	List only one ceus	e on each line.	itin. Do n	ot antar tha	mode of dying, suc	ch aa cardi	nc or reapi	ratory ar	reat,	Approximata Interval Between	
1	IMMEDIATE CAUSE (Fine)	MT OT	200111 01								Onset and Death	
	disease or condition reaulting in death)	MOLTI (JRGAN SY	STEM	FAILU	RE 2PERIN	ATAL .	ASPHY.	XIA		~24°	
	reacting in deatily	DUE TO (OR AS A CONSEO	UENCE OF):							
-	_											
CERTIFICATION	Sequentially list conditions,	b. DUE TO (OR AS A CONSEQ	UENCE OF	١٠							
A	if any, leading to immediate cause. Enter UNDERLYING	_	24211111 - 301-124									
유	CAUSE (Disease or Injury	C. DHE TO A	OR AS A CONSEO	HENCE OF								
ΙĒΙ	that initiated events requiting in death) LAST	502 10 (ON AS A CONSEC	DENCE OF);							
		d										
	PART II. Other aignificant condition	na contributing to	leath but not re	suiting i	n the underly	dag cause alves la	Doet i	4e. WAS AN	411770004	Lan		
EDICAL				outing i	i tha dhacil	ing cause given in		PERFOR	MED?		WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO	
盲								YES 2	□ NO		COMPLETION OF CAUSE OF DEATH?	
M											1 TYES 2 X NO	
	DID TOBACCO USE CONT	RIBUTE TO CAL	JSE OF DEAT	H YE	S NO	M UNCERTAI	NΠ					
PHYSICIAN	25. WAS CASE REFERRED TO MEDICAL				H (Check only o							
잃	EXAMINER? 1 YES 2 XNO	HOSPITAL:	en en en en en en en	7.00	OTHER:	78 -71 -33						
≚	27. MANNER OF DEATH					ome 5 Rasidence						
합	1 X Natural 5 Pending	28s. DATE OF I (Month, De		28b. TIME INJU	OF 28c.	INJURY AT WORK?	28d. DESC	RIBE HOW II	UJURY OC	CURED		
BY	2 Accident Investigation					YES 2 NO					1000	
	3 Suicida 8 Could not be	28a. PLACE OF building, e	INJURY — At hon to. (Specify)	te, farm, s	treet, factory, o	ffica	281. LOCAT	ION (Street &	nd Number	or Rural Ro	oute Number,	
핃	4 Homicide determined		. (,				City or	Town, State)				
COMPLET	29a. CERTIFIER 1 CERTIFYING PHYS	SICIAN: To the head of	na koomile dee ad	the en			3-2					
Σ		SICIAN: To the best of n										
8	2 MEDICAL EXAMIN		minimient and/or in	-ventigation	i, in my opinior	, death occured at the	time, data a	nd place, an	d due to th	is cause(s)	and manner as stated.	
l w li	296 SIGNATURE AND TITLE OF CERTIFIE					29c. LICENSE NUI	MBER		29d. DAT	E SIGNED	Month, Day, Year)	
0 8	Ciun J. Cabocujan	, HID.				D4440	FC		▶ 1	0/25/	/95	
۲	30. NAME AND ADDRESS OF PERSON WI	HO COMPLETED CAUSE	OF DEATH (ITEM	27) (Туре,	Print)							
	GRUIN 7. CABACONSAN), MP. (NE	ONATOLA	y)22	S GRE	ENE ST BA	LTIMO	RE, MD	#21	201		
								,	M marks			
	31. DATE FILED (NO P. 0°1 19	95 32. BEGULTHAR	Thursday N	whall								
		0										



ITEMS: 23 PART I, 27, PER MEO FILM G-729 11/20/95 t.t

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 -CERTIFICATE OF DEATH REG NO t. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH YEAR STEPHEN **ASUMAN** OCTOBER

7. DATE OF BIRTH
(Month, Day, Year) 995 2:40 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. Country) 25 N/A JNE 16. 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 4503 39th st. BRENTWOOD PRINCE GEORGES RESIDENCE OF DECEDENT 10b. COUNTY 10c, CITY, TOWN OR LOCATION 10a. STATE 10d. INSIDE CITY t X YES 2 NO MARYL AND BRENTWOOD PRINCE GEORGES FUNERAL 10g, CITIZEN OF WHAT COUNTRY? 101, ZIP CODE AFRICA 4503 39TH. 20722 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea or No-11. MARITAL STATUS 14. RACE — American Indian, Black, White, atc. It yes, specify Cuban, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify: FORCES? 1 YES 2 NO 1 X Never Married 2 Married Specify: BY 3 Widowed 4 Divorced **BLACK** ED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest ive kind of work done . Do NOT use retired.) during most of working ET Elamentary/Secondary (0-12) College (1-4 or 5+) COMPL UNEMPLOYED N/A 17. FATNER'S NAME (First, Middle, Lest) 18. MOTHER'S NAME (First, Middle, Maiden Surname) PETER BUADI **JULIANA** MANSA 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 FRIMPONG 4503 39TH STREET, BRENTWOOD, MD. 20722 **MANSO** 20a. METNOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE 1 Burisi 2 Cremation 3 Removal from State
4 Donation 6 X Other (Specify) SHIPPED OUT 11/2/95 DUAYAW-NKAWTA CEMETERY DUAYAW-NKAWTA 21. SIGNATURE OF PARTIAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY E.M. DUDLEY FUNERAL HOME 3200 R.I.AVE., MT.RAINIER, MD. 20712 23. PART I. Enter the diseases, or complications that ceused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fellure. Liet only one ceuse on each line. Approximata intervai Between **Onset and Death** IMMEDIATE CAUSE (Finel disease or condition MYOCARDITIS resulting in death) DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentieily list conditions, DUE TO (OR AS A CONSEQUENCE OF) If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disesse or Injury DUE TO (OR AS A CONSEQUENCE OF): that initieted events resulting in deeth) LAST PART II. Other aignificent conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY 24b, WERE AUTOPSY FINDINGS PERFORMED? AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 ES 2 NO 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 26. PLACE OF DEATN (Check only one 25. WAS CASE REFERRED TO MEDICAL OTHER:
4 □ Nursing Nome 5 □XRasidence HOSPITAL TY YES 2 NO 1 Donatient 2 ER/Outpetient 3 DOA 27. MANNER OF DEATN 28b. TIME OF 28d. DESCRIBE NOW INJURY OCCURED

1 X X Natural 2 Accident

6 Could not be

28a. DATE OF INJURY (Month, Day, Year)

26s. PLACE OF INJURY — At home, term, streat, factory, office building, etc. (Specify)

28c. INJURY AT WORK? 1 YES 2 NO

2 💢 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and piece, and due to the cause(s) and manner as stated.

111 Penn Street, Baltimore, Maryland 21201

281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 29a. CERTIFIER
(Check only one)

2 M MEDICAL EXAMINES: On the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CENTURIES

29c. LICENSE NUMBER O.C.M.E

29d. DATE SIGNED (Month, Day, Year) ▶OCTOBER 16,1995

ISE OF DEATH (ITEM 27) (Type, Print)

DENNIS CHUTE 31. DATE FILED (Month, OCT

TANGOSTI AS STRUCTURAL

BALTIMORE, MARYLAND 21215-0020 page 5 should be detached after death. Page 6 may be funeral director, the filled in by POULS completely BOX 6876 burial. and Hygiene prior to g OR ATTENDING PHYSICIAN: The law requires that the death certificate P.0. attending DIVISION OF VITAL RECORDS, Health and t, of I certificate has been the State Dept. of, or item 23 s the o this c. death death DIRECTOR: A

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TO THE FUNERAL ID be filed within 72 h 223

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SPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after de	NERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fi	thin 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunial, cremation, or removal.
he death certificate be	the attending physicial	Mental Hygiene prior
w requires that I	been signed by	nt. of Health and
PHYSICIAN: The lan	this certificate has	with the State Dec
PITAL OR ATTENDING	ERAL DIRECTOR: After	n 72 hours after death

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATN 35 A -roncis dams Octoper 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. lest birthday) 7. DATE OF BIRTH 8. BIRTNPLACE (State or Foreign IF UNDER 1 YEAR IF UNDER 24 HRS. March 13, 1928 Washington D.C TOM 2 DF 67 578-28-3196 9e. FACILITY NAME (If not institution, give street and number) 9c. COUNTY OF DEATN 9b. CITY, TOWN OR LOCATION OF DEATN DIRECTOR Prince George's Hospital Centre Cheverly Prince George's 10a. STATE 10b. COUNTY 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY 1 YES 2 1 NO MD Prince George's Capital Heights FUNERAL 10e. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? 6601 Wilburn Drive 20743 12. WAS DECEDENT EVER IN U.S. ARMEO FORCES? 1 YES 2 X NO 11. MARITAL STATUS 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, atc. FORCES? 1 YES 2 1 Never Married 2 Married If yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 YES NO Specify: Specify: BY 3 Widowed 4 Divorced Black. ETED 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highe Elementery/Secondary (0-12) College (1-4 or 5+) COMPL Insurance Under Writer Private once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) notified at Albert Adams Clara Dyson BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Bettie Adams 6601 Wilburn Dr. Capitol Heights, MD 20743 20s. METHOD OF DISPOSITION

1 Surial 2 Commelion 3 Removal from State
4 Donation S Other (Specific pe OSt 3 Washington D.C. 20b. PLACE AND DATE OF DISPOSITION (Name of must Donation S - Other (Specify) . examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY J.B. Jenkins Funeral Home 7474 Landover Rd. Landover, MD 20785 medicai 23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between ahock, or heert failure. List only one cause on each lina Onest and Death IMMEDIATE CAUSE (Final the disease or condition DUE TO (OF S A CONSEQUENCE OF): resulting in deeth) event. traumatic CERTIFICATION Sequentielly list conditiona, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disesse or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events reaulting in death) LAST 6 injury, PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL PERFORMED? AVAILABLE PRIOR TO апу COMPLETION OF CAUSE 1 TYES 2 ME NO Shows 2 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN has be Dept. 23 si PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) t the State I Item EXAMINER? OTHER: ☐ Inpetient 2 ☐ ER/Outpetient 3 ☐ DOA 4 - Nursing Home 10 27. MANNER OF OEATH 28s. DATE OF INJURY TIME OF 28c. INJURY AT 28d. OESCRIBE HOW INJURY OCCURED Brayebug marked, 1 Natural
2 Accident Bkdproken M 1 YES 2 NO sham DIRECTOR: After the hours after death item 28 is mari В 3 Suicide ETED 8 Could not be 4 Homicide 6101 29s. CERTIFIER 1 CERTIFYING PRYSICIAN: To the best of my knowledge, death occurred at the time, date and place, COMPL HOSPITAL FUNERAL WITHIN 72 H 2 MEDICAL EXAMINER: On the basis of axemination and/or investigation, in my opinion, death occurred at the lime, data IMPORTANT: DATE SIGNED (Month, Day, Year) BE 2

TO BE COMPLETED BY FUNERAL DIRECTOR

33888 95

ITEMS: 23 PART I, II, 27,28a-f, PER MEO FILM G-730 12/28/95 t.t

FOR STATE REGISTRAR	STATE OF	MARYLAI		RTMENT O		ALTH AND	MENTA	L HYGIEN			
1. DECEDENT'S NAME (First, Middle, Last)								OF DEATH			TIME OF OEATH
ROSLYN		ARM	STRONG	3			OC	ř. 10	, 199	AR	2:38 P.
4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (in	yrs. last birthday)	IF UNDER 1 YE		IF UNDER 24 HRS.	7. DATE	OF BIRTH	8, 8	BIRTHPL	ACE (State or Foreign
573-63-6544	1 M 2 XF		39 YRS.	MONTHS DA	Y'S	HOURS MIN.	Decen	ber 19,	1955	WTSC	onsin-lios
9a. FACILITY NAME (If not institution, give s	treet and number)	-		9b. CITY, TO	WN OR	LOCATION OF D	EATH		9c. COUNTY Prince	OF DEAT	H
GREATER LAUREL	BELTSV	ILLE		LAU					Prince	Geor	ge s
Maryland Prince	'George's		10c. CIT	Y, TOWN OR L	OCATIO	™ Suitlan	d				d. INSIDE CITY LIMITS?
100. STREET AND NUMBER 3510 Silver Park D	rive #14				10f. 2	ZIP CODE 20	468		10g. CITIZEN U.S.	OF WHA	T COUNTRY?
11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDED FORCES? 1 IF YES, GIVE N	YES	2 XNO	If yo	s, spec	NDENT OF HISPA Ify Cuben, Mexic	an, Puerto			Black, W	American Indian, thite, atc. B1aCk
15. OECEDENT'S EDU (Specify only highest grade	CATION	1	16a. DECEDENT'S				168	. KIND OF BU	SINESS/INOUST	RY	
Elementary/Secondary (0-12)	College (1-4 or 5	+)	life. Do NOT u	work done durin se retired.)	g most	or working					
12th grade			Nail Te	echnicia	n			Se	elf-Emplo	yed	
17. FATHER'S NAME (First, Middle, Lest)						18. MOTHER'S N	AME (First,	Middle, Malden	Sumame)		
Preston A	Armstrong							nda Warr			
19a. INFORMANT'S NAME (Type/Print)						Number or Rural					
Kathy Hunte						treet Mi		-			721
20e. METHOD OF OISPOSITION 1XXBuriel 2 Cremetion 3 Rem 4 Donation 5 Other (Specify)	oval from State		PLACE AND DATE Pery, crematory or o			e of	10/2		andover,		
21. SIGNATURA OF FLIMERAL SERVICE LIC 23. PART I. Enter the diseases, or ahock, or heart failure.	complications the	les it couned t	the death. Do	/ 43	39 F	ADDRESS OF F. IS FUNETA Hunt Plac e of dying, sur	Home 1 Home	e, Inc. Wash	nington,	D.C.	20019 Approximate
IMMEDIATE CAUSE (Finel disease or condition resulting in deeth)			ITY REACT	FION							Onset and Deat
			ONSEQUENCE C								
Sequentially liet conditions, if any, leeding to immediate	D		NJECTION CONSEQUENCE O		RAS	MATERIA	L				
cause. Enter UNDERLYING CAUSE (Disease or Injury	C.										
thet initieted events resulting in death) LAST	d	OR AS A C	CONSEQUENCE	OF):							
PART II. Other significant condition	s contributing to	death but	t not resulting	in the under	lying	ceuse given in	Part I.	24a. WAS AN			ERE AUTOPSY FINDINGS
OVARIAN DERMOID CYS	ST						_	YES :		C	MILABLE PRIOR TO OMPLETION OF CAUSE F DEATH? YES 2 NO
DID TOBACCO USE CONT	RIBUTE TO CA	AUSE OF	DEATH Y	ES NC		UNCERTA	IN \square				
25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		8. PLACE OF OE/					<u> </u>			
1 X YES 2 NO	1 Inpatient 2			4 Nursing		5 - Residence					
27. MANNER OF DEATH 1 Netural Pending	28e. DATE O (Month, 10-10-9	Day, Year)	28b. TII	JURY	WOR		CON	SCRIBE HOW FRAST MA OGRAPHY	TERIAL F	OR A	BOOMINAL OF
2 XXAccident Investigation 3 Suicide 8 Could not be	28e. PLACE	OF INJURY -	- At home, ferm,	•			-		and Number or I	Rural Rou	te Number,
4 Homicide 8 Could not be determined	building	, etc. (Specify	y)	REGIONAL		SPITAL		REL. MD.	7300 VA	N DU	SEN RD.
29a. CERTIFIER 1 CERTIFYING PHYS 2 MEDICAL EXAMIN	ICIAN: To the best of		dge, death occur	red at the time	, date s	ind place, and du	e to the ca	use(s) and me		ause(s) a	nd menner as stated.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the death of the following physician and completely filled in by the funeral director, page 5 should be detached for use as the burlat-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlat, cremation, or removal. DIVISION OF VITAL RECORDS, P.O. BOX 6876

BALTIMORE, MARYLAND 21215-0020

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DHMH-16 Rev 1/89

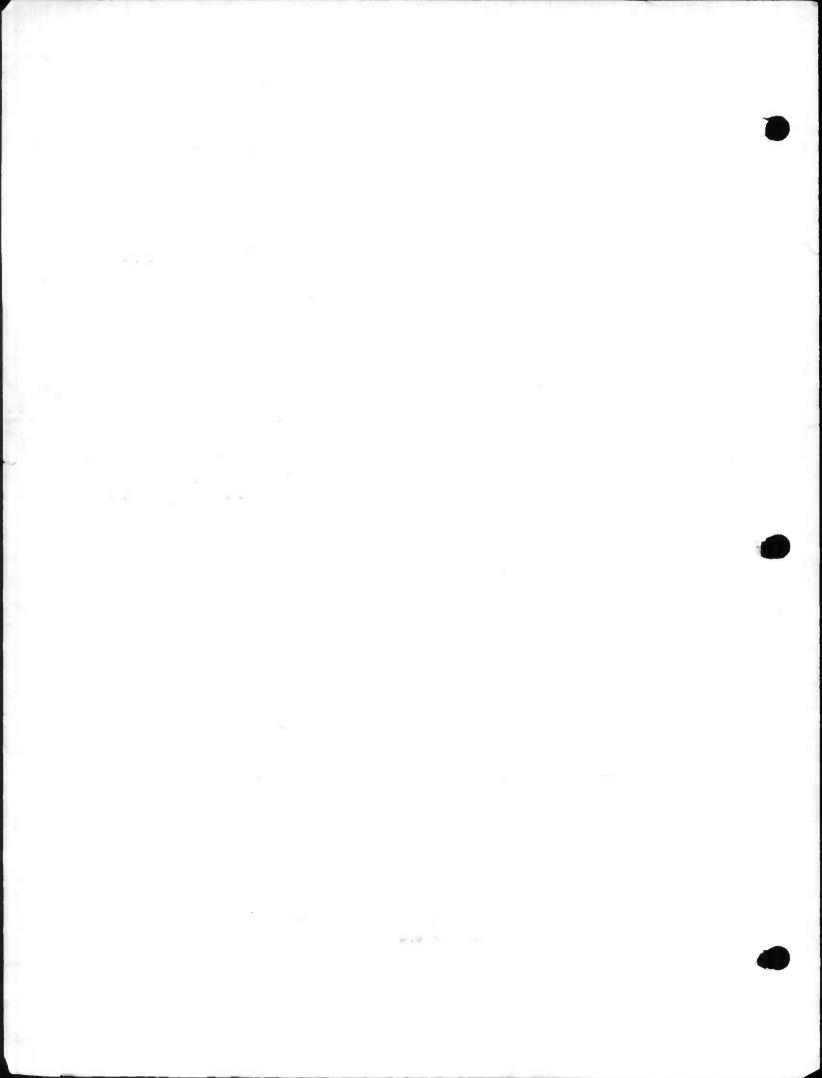
11,1995

29d. DATE SIGNEO (Month, Day, Year)

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O.C.M.E.

Penn Street, Baltimore, Maryland 21201



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	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours that the death Page 8 may be retained by the hospital or a	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the forms director, page 5 should be detached for us to filed within 72 hours after death with the State Debt, of Health and Mental Holiene prior to burial, cremation, or mental	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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	REGISTRAR	STATE OF MARYLAI		TMENT OF		MENTAL HYGIEN		
	1. DECEDENT'S NAME (First, Middle, Last)	Bro	NUN			2. DATE OF DEATH	2	YEAR 3. TIME OF DEATH
	270	SEX 6. AGE (In	yrs. last birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	120	BIRTHPLACE (State or Foreign Country) Maryland
OR	90. FACILITY NAME (If not institution, give street Dorchester Gene:		al	ob. CITY, TOWN	or Location of Di	EATH		nty of DEATH Chester
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		10c, CITY	Y, TOWN OR LOC	ATION			10d. INSIDE CITY
	Maryland Dorchester Cambridge 100. STREET AND NUMBER 101. ZIP CODE						10g. CIT	1 ₹ YES 2 □ NO
FUNERAL		Venue WAS DECEDENT EVER IN U FORCES? 1 YES		13. WAS DE	21613	NIC ORIGIN? (Specify Yes	US or No —	14. RACE — American Indian, Black, White, etc.
BY	1 Never Merried 2 Merried 3 Widowed 4 Divorced 15. DECEDENT'S EDUCATION	IF YES, OIVE WAR OR DATE	ES	1 🗆 YE	S 2 NO Specify	y:		specify: Black
COMPLETED	(Specify only highest grade com	ollege (1-4 or 5 +)		USUAL OCCUPAT FOR done during it retired.) - picke1	lost of working	16b. KIND OF BUI		Industry
	17. FATHER'S NAME (First, Middle, Last)		Club	preker		ME (First, Middle, Meiden		ndustry
H	Tony Anthony Pr	ritchett	195 MAILING	ADDRESS (Street		Phillips Route Number, City or Town	- 64-4- 7/-	0.41
5	Leona Spicer							faryland21622
	20e. METHOD OF DISPOSITION 1 N Burlel 2 Cremetion 3 Removal 4 Donation 8 Other (Specify)	from State cemete	LACE AND DATE Of or or or or or or or or or or or or or	F DISPOSITION (#	lame of	DATE 20c. LO	CATION —	City or Town, State h Creek, MD.
	21. SIGNATURE OF FUNERAL SERVICE LICENS	Jenne	0	Henr	y Funer	al Home		idae.Md.21613
	23. PART . Enter the diseases, or compensor, or heart feilure. List IMMEDIATE CAUSE (Final disease or condition resulting in desth)	only one cause on each	h line.	ot enter the m	ode of dying, suci	h as cardiac or reapi	ratory arr	Approximata interval Between Onset and Dasth
ATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A CO	ONSEQUENCE OF	120	Romic	Colilis		10 days
CERTIFICATION	CAUSE (Disease or Injury that initiated events resulting in death) LAST	DUE TO (OR AS A CO	ONSEQUENCE OF):				
PHYSICIAN: MEDICAL C	PART II. Other algorificant conditions condi	Vase Dis	CVA			PERFOR 1 YES 2	MED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
ICIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	OSPITAL:	PLACE OF DEAT	H (Check only one)			
	27. MANNER OF DEATH 1 Natural 5 Pending	28e. DATE OF INJURY (Month, Day, Year)	ent 3 DOA	4 Nursing Ho	JURY AT DRK? YES 2 NO	6 ☐ Other (Specify) 28d. DESCRIBE HOW II	NJURY OCC	CURED
TED BY	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	26e. PLACE OF INJURY — building, etc. (Specify)	At home, farm, s			281. LOCATION (Street e City or Town, State)	nd Number	or Rural Route Number,
COMPLET		: To the best of my knowleden the basic of examination of						ted.
BE	295. SIGNATURE AND TITLE OF CERTIFIER		eneay		29c. LICENSE NUM D/4	4BER		E SIONED (Month, Day, Year)
일	30 NAME AND ADDRESS OF DERSON WHO CO				1 / / "	- ' /		1 / ~ - / / 3

15 Franklin Street

19432. REGISTALAS SIGNATURE OF ROYALL

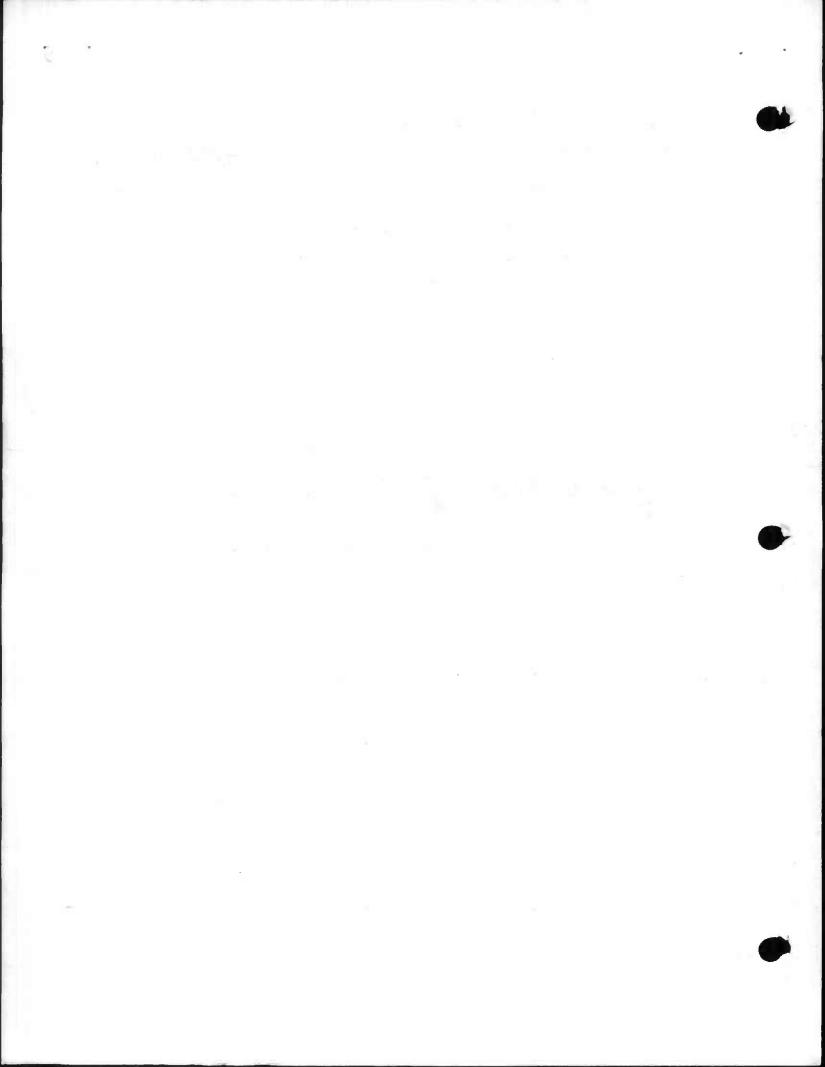
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

M.D

31. DATE FILED (Mo

Tanman,

29c. LICENSE NUMBER
2/4349 123/95 Cambridge, MD 21613



	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Est hours after death. Page 6 may be retained by the host	TO THE FUNEFAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache	moval.	IMPORTANT: if item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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	the deat	the att	Menta	Injury,
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	he law	e has	le Depi	m 23
	IAN: 1	tificat	e Stal	or ite
	4G PHYSIC	ter this ce	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene phor to burnal, cremation, or removal.	narked,
	ENDI	DR: At	ter de	8 18
	R ATT	RECT	urs at	ш 2
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	TO THE P	TO THE F	be filed w	IMPORT

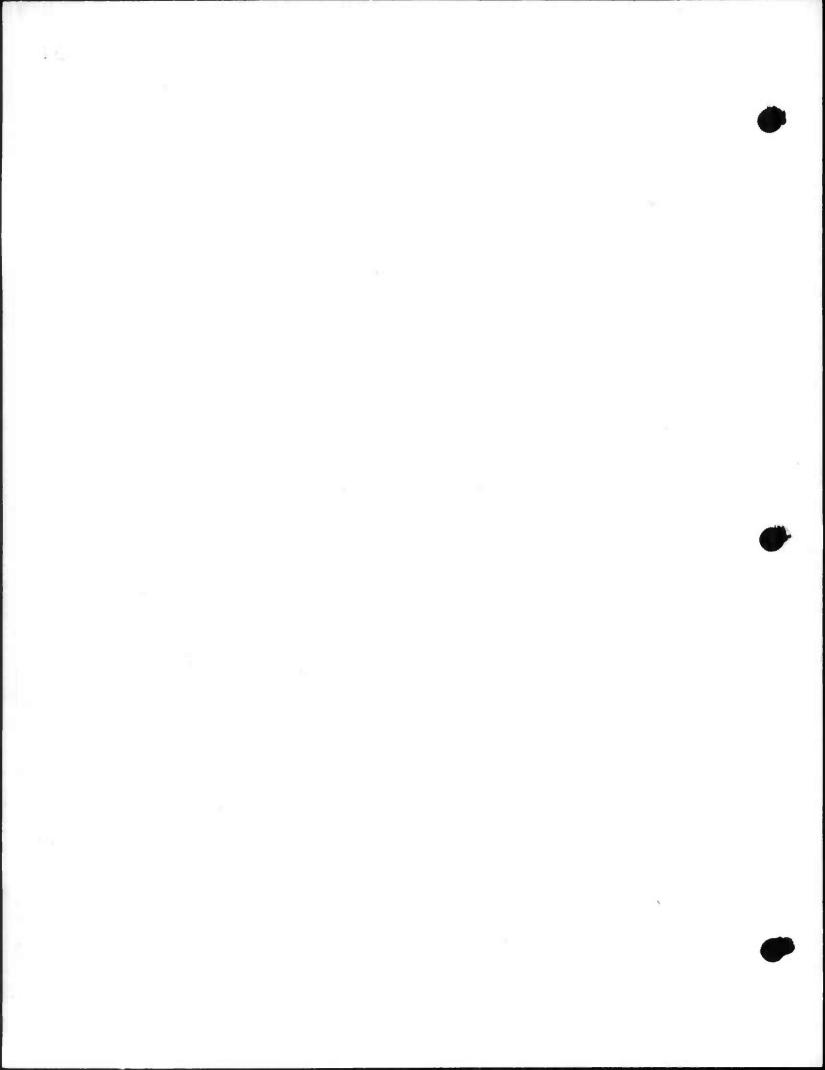
1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	negi5/nAN			EKIT	ICALE	UF	DEA	IH	REG. NO).		
	1. DECEDENT'S NAME (First, Middle, Last)	ALICE	ELLEN	BAN	NING				2. DATE OF GEATH MONTH October	25	YEAR 1995	3. TIME OF OEATH 2218 M
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. i	lest birthday)	IF UNDER 1	YEAR	IF UNDER	24 HBS	7 DATE OF BIRTH			PLACE (State or Foreign
	214-07-7534	1 □ M 2 🏋	85	YRS.	MONTHS	DAYS	HOURS	MIN.	July 25,	1910	Countr	ryland
	9a. FACILITY NAME (If not institution, give s				9b. CITY,	TOWN O	R LOCATION	ON OF DE	ATH	9c, COL	JNTY OF D	EATH
DIRECTOR	Dorchester Genera	ıl Hospita	al			Ca	mbri	dge		I	orch	ester
5	RESIDENCE OF DECEDENT									1		
쀭	10a. STATE 10b. COUNTY				Y, TOWN OF							10d. INSIDE CITY
	Maryland Do	rchester			Cambr	idg	e					1 YES 2 NO
4	100. STREET AND NUMBER					101.	ZIP CODE	E		10g. CIT		THAT COUNTRY?
FUNERAL	210 Meteor Avenu			_			216	13			U	
<u> </u>	11. MARITAL STATUS	12. WAS DECEDENT FORCES? 1	VES XX	RMED	13. W	AS OECI	ENDENT O	F HISPANI	C ORIGIN? (Specify Yes, Puerlo Rican, etc.)	a or No—	14. RACE	- American Indian, White, atc.
BY	1X Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE W		J.10	ï	YES	XX NO	Specify:	, Pourio Ricari, etc.)		Specifi	P 99 A
COMPLETED	15. OECEDENT'S EDU (Specify only highest grade		16a. C	DECEDENT'S	USUAL OC	CUPATIO	N of working		16b. KIND OF BI	SINESS/IN	DUSTRY	
	Elementary/Secondary (0-12)	College (1-4 or 5+) //	(Give kind of ville. Do NOT us			or OF WORKE	'V				
MP	17. FATHER'S NAME (First, Middle, Last)			Sale	s Cle	rk				il St	ore	
		ning					16. MOTH	Ter's NAM	ME (First, Middle, Maide a Jones	Surname)		
) BE	19a. INFORMANT'S NAME (Type/Print)			19b. MAILING	ADDRESS	(Street or	nd Number		oute Number, City or To	vn, State, Zi	(p Code)	
5	Bonnie Meyer			1700	Race	St	. Ca	mbri	dge, Mary	land	21613	3
	20a. METHOD OF DISPOSITION 1 Surial 2 Cremation 3 Ram	oval from State		E AND DATE O				1 .	0ATE 20c. L	OCATION -	City or To	wn, Steta
1	4 Donation 5 Other (Specify)	THEFT	1 010	Irini							reek	, Maryland
- 1	11) - 1)				Th	oma	s Fu	nera.	I Home, P	.A.		
	John L) 40	Jhrs-			70	00 L	ocus	t St	. Cambrid	ge, M	laryla	and 21613
	23. PARTY. Enter the diseases, or o shock, or heart feliure.	complications that	ceused tha d	death. Do n	ot antar t	he mod	de of dyl	ng, auch	es cerdiac or reep	elratory ar	rest,	Approximata
	IMMEDIATE CAUSE (Final						17					Interval Between Onset and Death
	disease or condition resulting in death)		/n.tra	ecla	ma	Q	Kon	ness	hage			10/22/95
	•,	OUE TO	OR AS A CONS	EOUENCE OF	7:			-6-6-1				
CERTIFICATION	Sequentially list conditions,	b. OUE TO (OR AS A CONS	EQUENCE OF	า:							
₹ I	If any, leading to immediate cause. Enter UNDERLYING											ĺ
Ĕ	CAUSE (Disease or injury that initiated evanta	DUE TO (OR AS A CONS	EOUENCE OF	7:							
E	resulting in death) LAST	d										
	PART II. Other eignificent condition	s contributing to	daath but not	resulting i	n the und	erlylna	Cause C	ilven in F	Part I, 24a, WAS AI	AUTOPSY	24b	WERE AUTOPSY FINDINGS
EDICAL	Hyperteusion							,	PERFO	RMED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE
	//sections								1 □ YES	2 NO		OF DEATH?
Σ	DID TOBACCO USE CONTI	PIRLITE TO CAL	ISE OF DE	ATH VE	s \square N	0 12	LINIC	EDTAIN				1 YES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL	NIBOTE TO CAL		ACE OF DEAT			ONC	EKIAIN				
길	EXAMINER?	HOSPITAL:			OTHER:	ny one,						
≥ I	1 TYES 2 NO	1 Inpetiant 2						aldenca 6	Other (Specify)			
	27. MANNER OF DEATH 1 Netural 5 Pending	28a. DATE OF (Month, De		28b. TIMI		WOF			28d. DEŞCRIBE HOW	INJURY OC	CURED	
B	2 Accident Investigation 3 Suicide & Could not be	26a. PLACE OF	INJURY — At I	home, ferm, s	treet, factor				28f. LOCATION (Street	and Numbe	e or Pumi B	nuto Mumber
COMPLETED	4 Homicide 8 Could not be determined	building, e	etc. (Specify)			y,			City or Town, State)	OF HOPET IN	oue number,
7	29a. CERTIFIER 1 CERTIFYING PHYSIC	CIAN: To the best of a	my knowledge o	death occurre	d at the tim	na deta	and place	and due t	o the cause(a) and ma		is a	
OM	(Check only one) 2 MEDICAL EXAMINE											and menner as stated.
	29b. SIGNATURE AND TITLE OF CERTIFIER							NSE NUME				(Month, Dev. Year)
BE		See.	wan	· m	12			143		•	10/2	26/95
유	30. NAME AND ACCRESS OF PERSON WHO											
	Eyup Tanman, M.D			Frank.	lin S	tre	et	(Cambridge	, MD	2161	13
	31. DATE FILED (1995) 1995	32 AGGISTRAF	S SIGNATURE	ardall								

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
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	1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPARTM CERTIFIC			MENTAL	HYGIEN REG. NO.			
		Harry Buckl	and			MONTH	of DEATH D	-	YEAR 996	TIME OF DEATH
	283-26-0190	X M 2 🗆 F 68	YRS. MO	UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	Apri	Day, Year) 1 25,	1927	West	ACE (State or Foreign
TOR	98. FACILITY NAME (If not institution, give street Residence: 86 Will RESIDENCE OF DECEMENT		94		ng Sun	EATH		9c. COUN	Ceci	
DIRECTOR		Cecil	10c. CITY, T	OWN OR LOCAT	ng Sun					0d. INSIDE CITY LIMITS?
FUNERAL	86 Wilson Road				219			Ţ	J.S.A	
BY	1 Never Married 2 Married	2. WAS DECEDENT EVER IN FORCES? 1 X YES IF YES, GIVE WAR OR DA W.W.II & KO	2 NO	If yea, ap-	ENDENT OF NISPAI edity Cuberi, Mexica 2 XNO Specif	an, Puerto Ri	(Specify Year Ican, etc.)	or No—	Black, 1	- American Indian, White, atc. White
COMPLETED	15. DECEDENT'S EDUCAT (Specify only highest grade co	TION mpleted) College (1-4 or 6+) X Years	16m. DECEDENT'S USI (Give kind of work life. Do NOT use no Food Ser	done during mo dired.)	t of working	Ce		nty Sc	hool o	of Technology f Education
BE COM	17. FATNER'S NAME (First, Middle, Lest) Harry B		1000 001	vice ii	18. MOTNER'S NA	ME (First, M		Surname)	ard O.	I HUCACIOI
TO B	Bettie Lou Taylor	Buckland			nd Number or Rurel d, Risin					11
	20s. METNOD OF DISPOSITION 1 Burisl 2 Cremetion 3 Remove 4 Donetion 5 Other (Specify)	of from State Care	PLACE AND DATE OF DE CONTROL OF C	emetery	10,		5 Cal	cation - c Lvert		
	21. SIGNATURE OF FUNERAL SERVICE LICEN	AHELLO	x, 5.	Lee A.	Patters ille, Ma	son &			al Ho	me
	23. PART I. Enter the diseases, or con shock, or heart fellure. Lis iMMEDIATE CAUSE (Final disease or condition	nplications that caused it only one cause on each of the course on each of the course on each of the course on the course on the course on the course of the	sch line.	enter the mod	de of dying, suc	ch ss cerdi	ec or respi	ratory srre	st,	Approximeta interval Between Onset and Death
_	resulting in death)		CONSEQUENCE OF):							years
CERTIFICATION	Sequentially llat conditions, if any, isading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury		CONSEQUENCE OF):				•			
CERTI	that initiated events resulting in death) LASY	DOE TO (ON AS A	CONSEQUENCE OF);							
PHYSICIAN: MEDICAL	PART II. Other significant conditions of	contributing to deeth be	ut not resulting in t	he underlying	ceuse given in		24a. WAS AN PERFOR	MED?	A	PERE AUTOPSY FINDINGS WAILABLE PRIOR TO OMPLETION OF CAUSE F DEATH?
AN: ME	DID TOBACCO USE CONTRIE				UNCERTAIN	N 🗆			1	YES 2 NO
/SICI/		IOSPITAL:	26. PLACE OF DEATN (Continue of the street o	THER:	5 K Rasidence	8 Other	(Specify)			
BY PHY	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF	M 28c. INJU WOI	IRY AT	Y	CRIBE NOW IN	YJURY OCCU	JRED	
	3 Suicide 6 Could not be detarmined	28e. PLACE OF INJURY building, atc. (Speci	— At home, farm, atree	rt, factory, office			TION (Street a r Town, State)	nd Number o	r Rural Rou	te Number,
COMPLETED	000) 2 MEDICAL EXAMINER:	N: To the best of my knowled the basis of axamination								nd manner as stated.
TO BE	296. SIGNATURE AND TITLE OF CERTIFIER A A A A A A A A A A A A A A A A A A A	OMPLETED CAUSE OF DE	NTN (ITEM 27) (Tyrne Pric	ort)	29c. LICENSE NUN	14		Doct 1	ober	
	H Farkaz MD,	Wurthern 32. REGISTRAR'S SIGN	Chesay	o cake	Hospica	e El	kton	MD	21	921
	OCT 31 1995 Ju	a Davidson-Ra	dall							DHMH-15 Rev 1/89



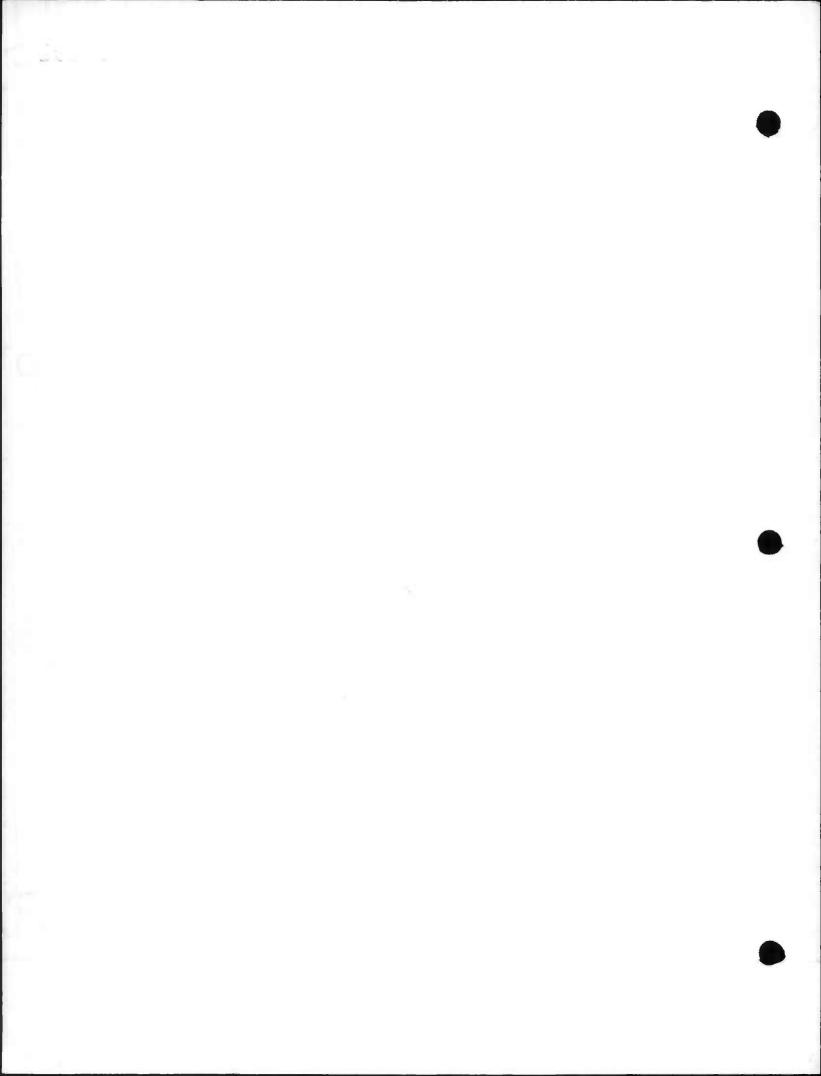
E BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a fours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit be filed within 72 hours after death with the State Detx, of Health and Mental Hydiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
TO THE	THE F	IMPORT

permit. Pages 1, 2, 3 should

	1 - STATE REGISTRAR	STATE OF MARYL		MENT OF H		MENTAL HYGIEI				
Ş	1. DECEDENT'S NAME (First, Middle, Last)			<u> </u>	Dianii	2. DATE OF DEATH MONTH	DAY YEAR	3. TIME OF DEATH		
		ae Powell Bo	wden In yrs. last birthday)			October 2	1995	4:15 A M		
		1 M 2 X F 98		IF UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) NOV. 24, 18	396 8. BIRT	HPLACE (Stote or Foreign Maryland		
~	9a. FACILITY NAME (If not institution, give stre				R LOCATION OF D	EATH	9c. COUNTY OF	DEATH		
DIRECTOR	Residence: 1663	Perryville R	Road	Pe	erryvill	e		Cecil		
REC	10e. STATE 10b. COUNTY	2	toc. CITY,	TOWN OR LOCAT			10d, INSIDE CITY LIMITS?			
	Maryland (Cecil			erryvill	e	Tan CITITEN OF	t YES 2 NO		
FUNERAL	1663 Perryville I	Road		101.	2190	3		U.S.A.		
FUN	11. MARITAL STATUS 1 Never Married 2 Merried	500000				NIC ORIGIN? (Specify Year, Puerto Rican, etc.)		CE — American Indian, ck, White, etc.		
B	Widowed 4 Divorced IF YES, GIVE WAR OR DATES			1 TES			Spe	White		
COMPLETED	15, DECEDENT'S EDUCA (Specify only highest grade or	iTION ompleted)	18e. OECEDENT'S U	ork done during mos		16b. KIND OF BU	JSINESS/INDUSTRY			
PLE	Elementary/Secondary (0-12) Six Years	College (1-4 or 5+)	iii. Do NOT use	emaker			Home			
NO.	17. FATHER'S NAME (First, Middle, Last)		TIOIN	andrees.	18. MOTHER'S NA	AME (First, Middle, Maide		141		
BE (edok Powell				Jannie A.	00			
2	190. INFORMANT'S NAME (Type/Print) June E. Gobble					Route Number, City or To Perryvill		and 21903		
	20a METHOD OF DISPOSITION 1 Buriel 2 Cremation 3 Remov	rat from State	PLACE AND DATE OF	DISPOSITION (Na.	me of	OATE 20c. L	OCATION — City or 1	fown, State		
	4 Donetion 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICE	S	etery, cremetory or oth				rryville	, Maryland		
	home of home	DHIEL	m 50	Lee A		rson & Son		Home		
Н	23. PART I. Enter the diseases, or co	mplications that caused	the deeth. Do no	Perry	VILLE. I	Maryland 2	1903 piratory arrest,	Approximate		
	shock, or heart failure. LI IMMEDIATE CAUSE (Final	at only one cause on e	ach lina.	1				Interval Between Onset and Death		
	disease or condition resulting in death)	Cardia	CONSEQUENCE OF	une	_					
z		Artons	Schongt	VC CAN	2/10/17	scular	dise	20		
AT 10	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	DUE TO OR ASA	CONSEQUENCE OF)	:	V VV (1. 16.0)	00-00				
FIC	CAUSE (Disease or Injury that initieted events	DUE TO (OR AS A	CONSÉQUENCE OF)			1				
CERTIFICATION	resulting in death) LAST	Chrows	Obstr	relie	e pru	monun	+ duce	icse		
AL C	PART II. Other significent conditions	contributing to deeth b	ut not resulting in	the underlying	ceuse given in		N AUTOPSY 24	b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO		
MEDIC						1 TES		COMPLETION OF CAUSE DF DEATH?		
: ME	DID TOPACCO HEE C		CAUGE OF	DEATH 1		_		1 YES 2 NO		
PHYSICIAN:	DID TOBACCO USE CO		CAUSE OF		ACE OF DEATH (CI	244				
YSIC	1 VES 2 NO	HOSPITAL: 1 Inpetient 2 ER/Outp		OTHER: 4 - Nursing Hom	5 Aesidence	6 Other (Specify)				
	27. MANNER OF DEATH 1 Meturel 5 Pending	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME INJU	RY WO	URY AT RK? ES 2 NO	28d. OEŞCRIBE HOW	INJURY OCCUREO			
э ву	2 Accident Investigation 3 Suicide 8 Could not be	28e. PLACE OF INJURY building, etc. (Spec	At home, farm, st			281. LOCATION (Street	end Number or Rural	Route Number,		
ETEI	4 Homicide determined	bullaing, etc. (Spec	:#Y)			City or Town, State	1)			
COMPLETED	one)	AN: To the best of my knowl								
	2 MEDICAL EXAMINER:	On the basis of examination	n end/or investigation	, In my opinion, d						
BE (200 SIGNATURE AND TITLE OF CENTIFIER	, Mi	0		29c, LICENSE NU	MBER	29d. DATE BIGHE	35T/91-		
10	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DE	ATH (ITEM ET) (Type,	/ 1	K	11 .				
	31. DATE FILED (Month. Day. Year)	32. REGISTRAR'S SIGN	ATURE	mon	ALR	Halme	ac O	vale.		
	OCT 3 0 1995	ion obwelson ha	rdall			*				



TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ex nours after death. Page 6 may be retained by the hospital or attending physician.

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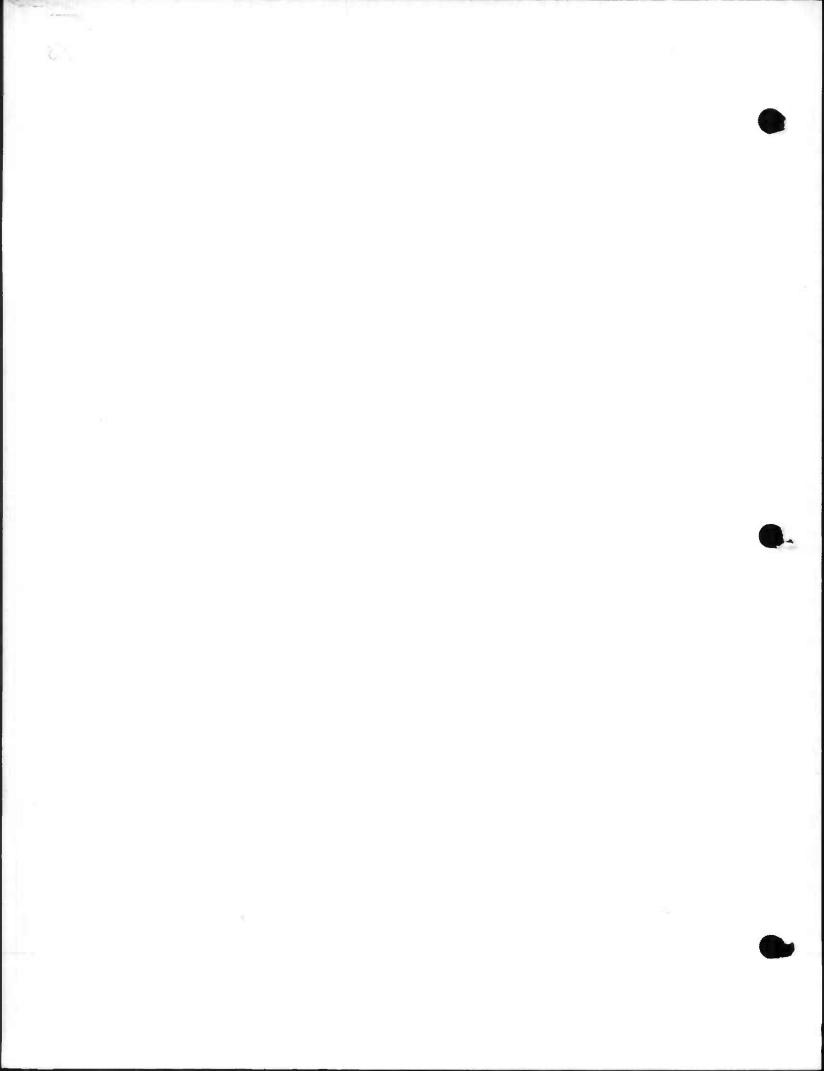
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

1 - STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO.

	REGISTRAN			Enin	CATE	OF L	JEAI	П	HEG. NO.			
Ì	1. DECEDENT'S NAME (First, Middle, Last)	Ann Lyn	n Bro	ck				2	DATE OF DEATH DA	.,	YEAR	3. TIME OF DEATH
- 1	4. SOCIAL SECURITY NUMBER	5. SEX 6	L AGE (In yrs. In:	st birthday)	IF UNDER 1 Y	EAR	IF UNDER 2	4 HRS. 7	DATE OF BIRTH	7 7 / 7	//	LACE (State or Foreign
	218-72-1658	1 🗌 M 2 💢 F	37	YRS.		_	HOURS	MIN.	(Month, Day, Year) uly 23, 1	958	Country)	land
	9e. FACILITY NAME (If not institution, give st	reet and number)			9b. CITY, TO	WN OR	LOCATION				NTY OF DE	
DIRECTOR	223 Melbourne Bo	ulevard	rd Elkton Cecil									
E I	10e. STATE 10b. COUNTY			10c, CIT	Y, TOWN OR I	OCATIO	N.					IOd. INSIDE CITY
								LIMITS?				
FUNERAL	100. STREET AND NUMBER 223 Melbourne Bo	ulevard					21921	1			S.A.	IAT COUNTRY?
3	11. MARITAL STATUS	12. WAS DECEDENT	EVER IN U.S. AF	RMED	13. WAS	DECEN	IDENT OF	HISPANIC	ORIGIN? (Specify Yes	or No	14. RACE -	- American Indian.
	1 Never Married 2 X Merried	FORCES? 1 F		NO	If y	s, speci	Y NO	, Mexican, f	Puerto Rican, etc.)		Black,	White, etc.
B	3 Wildowed 4 Divorced		TON DATES			103 2	A NO	Specify.			Specify	White
	15. DECEDENT'S EDUC (Specify only highest grade	CATION completed)	(0	live kind of v	USUAL OCCL				16b. KIND OF BUS	INESS/INC	DUSTRY	
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)	1	omema					None			
NO	17. FATHER'S NAME (First, Middle, Last)			Omema	ite I	T	18. MOTHE	ER'S NAME	(First, Middle, Malden	Sumama)		
BE C	Frank L.	Pensel							Elnora Du			
10 8	19a. INFORMANT'S NAME (Type/Print)								te Number, City or Town			
F	William C. Brock			223 M	elbou:	rne	Boul		d - Elkto			1921
	20s, METHOD OF DISPOSITION 1 Burisi 2 Cremation 3 Remo	oval from State	20b. PLACE cemetery, cre	AND DATE O	or Mei	N/Name	eo≀ ial I	Park	10 ⁴ 26 20c. LO	CATION —	City or Tow	n, State
1	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE	1F-		22. NA	ME AND	ADDRESS	S OF FACIL	1992 211	ccon,	mary	Tund
	Dan 1	2 N.	1						Funerals,			21921-5521
	23. PART I. Enter tha diseases, or o	omplications that	caused tha de	eath. Do n	ot antar th	W .	ot dvin	a. such a	St., Elk	ratory an	reat.	Approximata
	shock, or heart fallure.	List only one cause	on asch iln	D.						,		Interval Between Onset and Desth
	disease or condition	Meta	static	Car	rcy	4	Cer	VIX				2 years
	,	DUE TO (O	R AS A CONSE	OUENCE OF	F):	/				_		
CERTIFICATION	Sequentially list conditions, it any, leading to immediate	DUE TO (O	R AS A CONSE	OUENCE OF	7 :							
CAT	cause. Enter UNDERLYING CAUSE (Disesse or Injury	h										
E	that initiated events resulting in death) LAST	DUE TO (O	R AS A CONSE	OUENCE OF	F):							
崽		ı			-							-
	PART II. Other aigniticant condition	contributing to d	eath but not	reauiting i	in tha unde	riying o	cause gl	ven in Pa				WERE AUTOPSY FINDINGS
EDICAL									PERFOR	-		NMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
MEC												YES 2 NO
	DID TOBACCO USE (CONTRIBUTE	TO CAU	SE OF	DEATH	YE	S 🔲	NO	X			
ĕ	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:				26. PLAC	CE OF DE	ATH (Check	only one)			
YSI	1 - YES 2 NO	1 Inpatient 2 I E	ER/Outpatient	3 🗆 DOA	OTHER:	Home	5 K Resi	idence 6	Other (Specify)			
PHYSICIAN:	27. MANNER OF DEATH 1 Natural 5 Pending	28s. DATE OF IN (Month, Day,		28b. TIM INJ	URY	c. INJUR	C?		d. DESCRIBE HOW II	NJURY OC	CURED	
B	2 Accident Investigation 3 Suicide B Could not be	28e. PLACE OF	INJURY — At he	ome, ferm, s			S 2 🗌		Bf. LOCATION (Street a	and Number	or Purei Po	ida Mumbar
COMPLETED	4 Homicide B Could not be determined	building, et	c. (Specify)			071100		1	City or Town, State)	and Humber	or noval no	ote numos,
١٣	29a. CERTIFIER 1 CERTIFYING PHYSI	CIAN: To the best of m	y knowledge, de	eath occurre	ed at the time	, data ar	nd place, o	end due to	the cause(e) and man	ner se sta	lad.	
OM												and manner as stated.
BE C	29b. SIGNATURE AND TITLE OF CERTIF ET					12	29c. LICEN	NSE NUMBE	R	29d. DAT	E SIGNED (Month, Day, Year)
TO B		1, MI						314		De Ou	tuber:	24, 1995
-	30. NAME AND ADDRESS OF PERSON WHO						2	39 S	Bridge	STre	et	
	Dr. Henry Farkas	Northern	1 Chesa	peake	Hosp	ice	E	Iktor	n, MD 219	21		
	31. DATE FILED (4/00) DOX 7 1995	Jalia da	valen-Ra	Mall								



TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within and local feath. Page 6 may be retained by the hospital or attending physician.

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BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

REGISTRAR		CEF	RTIFICATI	E OF DE	ATH	REG. NO).		
1. DECEDENT'S NAME (First, Middle, Last)	Shirley 1	Milford	Rlake				AY 104	YEAR	. TIME OF DEATH
	-					October 2			0917
4. SOCIAL SECURITY NUMBER 234-30-3719	5. SEX 8. A	GE (In yrs. lest bl	YRS. IF UNDER	DAYS HOL	INDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year) Sept. 1,		Country)	ACE (State or Foreign
9a. FACILITY NAME (If not institution, give	atreet and number)		9n CITY	, TOWN OR LO	CATION OF DE			TY OF DEA	
Union Hospital		unty		lkton			Cec		
RESIDENCE OF DECEDENT 10a, STATE 10b, COUNT	TV	1	Oc. CITY, TOWN	OR LOCATION					Od, INSIDE CITY
Maryland Cec			E1ktor						LIMITS?
10e. STREET AND NUMBER				101. ZIP					AT COUNTRY?
134 West Thomso	n Drive			21	.921		U.	S.A.	
11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVE FORCES? 1 [XY IF YES, OIVE WAR O 1939 - 19	ES 2 NO R DATES			Cuban, Maxica	IIC ORIGIN? (Specify Yen, Puarto Rican, atc.)	e or No-	14. RACE - Black, Specify:	- American Indian, White, atc. White
15, DECEDENT'S EDI (Specify only highest grad	UCATION	15a. DECE	DENT'S USUAL O	CCUPATION	endrina -	16b. KIND OF BU	JSINESS/INDI	USTRY	
Elementary/Secondary (0-12)	College (1-4 or 5+)	IIIe. Do	NOT use retired.)	ouring most or	YORNING				
12		Pro	duction	ı		Thioko	1 Cor	porat	ion
17. FATHER'S NAME (First, Middle, Last)				18,	MOTHER'S NA	ME (First, Middle, Maide			
Thomas B	таке	100				Minnie H			
19a. INFORMANT'S NAME (Type/Print) Evalena H. Blak	e					Route Number, City or To , Elkton,		1921	
20a METHOD OF DISPOSITION 1 N Burial 2 Cremation 3 Res	moval from State	20b. PLACE AND cerpetery, crama G1 I D1 n	DATE OF DISPO	SITION (Nama of	1 Parl	10 ^{AJ} 28 ^{20c. L} 1995 E1	kton.	Mary	n, State
21. SIGNATURE OF FUNERAL SERVICE L			22.	NAME AND A	DRESS OF FA	CILITY			
Donard	l Hick	(As				r Funerals on Street,			D 21921
IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Supsis, but to (or a continuo or a contin	AS A COMBEQUE	plical						Onset and Dae 2d 16d.
PART II. Other significant condition					use given in	PERFO	N AUTOPSY DRMED? 2 NO		WERE AUTOPSY FINDING MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? THE YES 2 THO
			OF OEATN (Check						
25. WAS CASE REFERRED TO MEDICAL	HOSPITAL:	Outpatient 3	DOA 4 Nu		Residence	6 Other (Specify)			
EXAMINER?			26b. TIME OF	28c, INJURY		28d. DESCRIBE NOW	INJURY OCC	CURED	
EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH	28a. DATE OF INJU (Month, Day, Ye		INJURY	WORK?					
EXAMINER?	28a. DATE OF INJU (Month, Day, Ye		INJURY M	1 TES	2 NO				
EXAMINER? 1	28e. DATE OF INJU (Month, Day, Ye	URY — At home	M	1 □ 123	2 ☐ NO	261. LOCATION (Stree City or Town, Stat		or Rural Ro	ute Number,
EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 2 Accident Investigation 3 Suicide 5 Could not be detarmined 29a. CERTIFIER (Check only IN CERTIFYINO PHY	28a. DATE OF INJU (Month, Day, Ye	JURY — At home (Specify)	, farm, street, fee	1 TES	placa, and due	City or Town, State	enner as stat	od.	
EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 2 Accident Investigation 3 Suicide 5 Could not be detarmined 29a. CERTIFIER (Check only IN CERTIFYINO PHY	28s. DATE OF INJU (Month, Day, Ye 28s. PLACE OF IN, building, etc. (SICIAN: To the best of my NER: On the besis of examin	JURY — At home (Specify)	, farm, street, fee	1 YES	placa, and due	City or Town, Stell to the cause(a) and months, data and place,	enner as stat	ed.	
EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 2 Accident 8 Could not be detarmined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINE 29b. SIGNATURE AND TITLE OF CERTIFIER 1 MEDICAL EXAMINE 29b. SIGNATURE AND TITLE OF CERTIFIER 1 MEDICAL EXAMINE	28a. DATE OF INJU. (Month, Day, Ye 28a. PLACE OF IN. building, etc.) SICIAN: To the best of my interest on the basis of axamis	IURY — At home Specify)	n, farm, street, face	1 YES	place, and due	City or Town, Stell to the cause(a) and months, data and place,	enner as stat	ed.	and manner as stated.
EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 2 Accident 8 Could not be detarmined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINE 29b. SIGNATURE AND TITLE QCCERTIFIED 30. NAME AND ADDRESS OF PERSON W	28a. DATE OF INJU (Month, Day, Ye 28a. PLACE OF INJudicial Place of INJudicial Place of Injudicial Place o	IURY — At home Specify) knowledge, death attorn and/or inv	n, farm, street, face	1 ves ttory, offica Ilme, deta and opinion, death	place, and dur occured at the LICENSE NU	City or Town, Stell to the cause(a) and months, data and place,	enner as states and due to the	ed. cause(a) E SIGNED (and manner as stated. Months Day, Year)
EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 8 Could not be detarmined 29a. CERTIFIER (Check only One) 2 MEDICAL EXAMINED 29b. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WERE COMMENTAL COM	28s. DATE OF INJU (Month, Day, Ye building, etc.) 28s. PLACE OF IN, building, etc.) 28s. PLACE OF IN, building, etc.) 28s. PLACE OF IN, building, etc.)	IURY — At home Specify) unowledge, death nation and/or inv	M s, farm, street, fed h occurred at the restigation, in my	1 ves ttory, offica Ilme, deta and opinion, death	placa, and due occured at the LICENSE NU High	city or Town, Stales to the cause(a) and months, data and place,	enner as states and due to the	ed. cause(a) E SIGNED (and manner as stated. Months Day, Year)
EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 2 Accident 8 Could not be detarmined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINE 29b. SIGNATURE AND TITLE QCCERTIFIED 30. NAME AND ADDRESS OF PERSON W	28a. DATE OF INJU (Month, Day, Ye 28a. PLACE OF INJudicial Place of INJudicial Place of Injudicial Place o	IURY — At home Specify) unowledge, death nation and/or inv	M s, farm, street, fed h occurred at the restigation, in my	tory, office	placa, and due occured at the LICENSE NU High	City or Town, Stales to the cause(a) and months, data and place, MBER Street,	enner as states and due to the	ed. cause(a) E SIGNED (and manner as stated. Months Day, Year)

5 +14 # Cuell

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH MONTH 1995 Ima Rose Bartlett 1: 30 P October 0 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign April 199-05-4785 1 M 2 N F 90 YRS. 30. Virginia 1905 Pages 1, 2, 3 should Sa. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF OEATH 9c. COUNTY OF DEATH DIRECTOR Residence: 354 Blythedale Road Port Deposit Cecil RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Cecil Port Deposit 1 - YES 2 1 NO permit. 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 354 Blythedale Road 21904 funeral director, page 5 should be detached for use as the burial-transit U.S.A. retained by the hospital or attending physician. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No— If yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES RACE — American Indian, Black, White, etc. BALTIMORE, MARYLAND 21215-0020 II yes, specify Cuben, Mexican, Puerto Ri 1 ☐ YES 2 ☑ NO Specify: 1 X Never Married 2 ☐ Married BY 3 Widowed 4 Divorced Specify: White COMPLETED 15. DECEDENT'S EDUCATION ecity only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Spi Elementary/Secondary (0-12) College (1-4 or 8 +) Four Years Social Worker State of Pennsylvania 17. FATHER'S NAME (First, Middle, Lest) 18. MOTHER'S NAME (First, Middle, Meiden Surname) William James Bartlett BE Minnie Cole notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Mrs. Carol G. Simkin Box 110, Waccabuc, New York 10597 death. Page 6 may be 9 20s. METHOD OF DISPOSITION
1. Burlel 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION - City or Town, State must Hopewell Cemetery

Hopewell Cemetery 4 Donation 6 Other (Specify) 10/27/95 Port Deposit, Maryland examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSE 22. NAME AND ADDRESS OF FACILITY Lee A. Patterson & Son Funeral Home Perryville, Maryland and completely filled in by the burial, cremation, or removal. hours after medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart fellure. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Final Onset and Death the state Congrestive Fartures disease or condition_ cart 5 days reaulting in death) traumatic event, DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF): 2 the attending physician I Mental Hygiene prior to If any, leading to immediate cause. Enter UNDERLYING other CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 10 PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE MEDICAL 24a. WAS AN AUTOPSY PERFORMED? signed by the tent or linein amy 1 - YES 2 1 10 OF DEATH? 1 _ YES 2 _ NO been s DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square PHYSICIAN: DIRECTOR: After this certificate has by hours after death with the State Dept. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL 1 TES 2 NO OTHER: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Home 5 Residence 6 Other (Specify) -27. MANNER OF DEATH 26e. DATE OF INJURY (Month, Day, Year) this c 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. OESCRIBE HOW INJURY OCCURED marked, 1 Natural м 1 YES 2 NO BY Investigation 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street end Number or Rural Route Number, City or Town, State) 99 3 Suicide COMPLETED 8 Could not be 4 Homicide 29e. CERTIFIER

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data end piece, end due to the cause(e) and manner as stated. FUNERAL I 2 MEDICAL EXAMINER: On the besis of examination end/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(a) end menner es stated. TO THE HOSPITA
TO THE FUNERA
DE filed within 7
IMPORTANT: 1 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE w

2

Dunan

K ammydin 31. DATE FILED (Month, Day, Year)

OCT 26, 1995

30. NAME AND AGORESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print

Mithan MD.

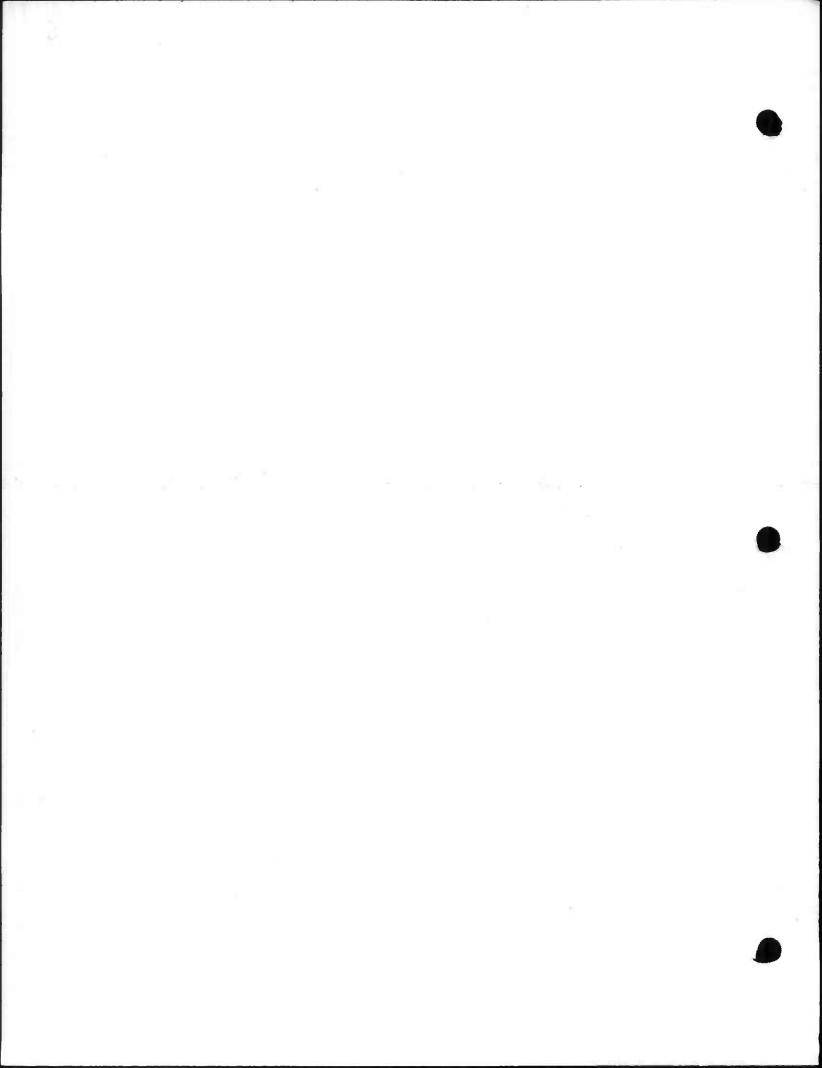
32. REGISTRAR'S SIGNATURE Stwales Reveal

10 h3 las

avre De Grace MD 21678

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STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

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Belinda Bradford Susan October 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH IF UNDER 24 HRS. NOV 26 1 M 2 XX 213-08-7252 25 YRS permit. Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH Southern maryland hospital Cent Clinton DIRECTOR RESIDENCE OF DECEDENT 10a. STATE 10c. CITY, TOWN OR LOCATION 10b. COUNTY Maryland Prince George's Capitol Heights FUNERAL IO. STREET AND NUMBER be detached for use as the burial-transit 7718 Beechnut Road 20743 retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-If yee, specify Cuben, Mexicen, Puerto Ricen, atc.)

1 YES 2 NO Specify: 1 Never Married 2 Merried ВУ 3 Widowed 4 Divorced COMPLETED 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION (Spe Elementary/Secondary (0-12) College (1-4 or 5+) 12 Gordons Retail Management 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) Robert Edward Bradford Sarah Jane Brennan BE page 5 should notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 7718 Beechnut Road, Capitol Heights, MD 20743 Robert E. Bradford 2 9 . METHOD OF DISPOSITION

Burlel 2 Cremellon 3 Removal from State Раде 6 тау 20b. PLACE AND DATE OF DISPOSITION (Name NOV 1, 1995TE must funeral director, Resurrection Cemetery Donation 5 Other (Specify) examiner 21. SIGNATURE OF FUNCTIAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Lee Funeral Home, Inc 6633 completely filled in by the funera rial, cremation, or removal. d medical 23. PART I. Enter the diseases, or complications that caused tha deeth. Do not enter the mode of dying, such as cerdiac or reepiratory arrest, shock, or heart fellure. List only one ceuse on each line. n and completely filled it to burial, cremation, or IMMEDIATE CAUSE (Final the disease or condition_ event. resulting in death) DUE TO (OR AS A CONSEQUENCE OF executed traumatic CERTIFICATION Sequentially list conditions. if any, leading to immediate attending physician ntal Hygiene prior to the death certificate be cause. Enter UNDERLYING CAUSE (Disease or injury other DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST 5 has been signed by the atte Dept. of Health and Mental injury. PART II. Other algorificant conditions contributing to death but not recuiting in the underlying ceuse given in Part I. PHYSICIAN: MEDICAL that any requires shows DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN SW. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) certificate I HOSPITAL OR ATTENDING PHYSICIAN: 1 YES 2 NO Inpatient 2 - ER/Outpatient 3 - DOA ng Home 5 Residence 8 Other (Specify) 0 the 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? this c marked. 1 Hatural 5 Pending 1 YES 2 NO BY After death Investigation 2 Accident DIRECTOR: At hours after de item 28 is n 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 3 Suicide ETED. 6 Could not be 4 Homicide hours 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end manner as stated. COMPL TO THE HOSPITAL (
TO THE FUNERAL D
Be filed within 72 h
IMPORTANT: If II (Check only one) HOSPITAL 2 MEDICAL EXAMINER: On the beste of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(e) end manner ee stated. MONATURE AND TITLE OF CERTIFIER 29C. LICENSE NUMBER BE 0 NE AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32. REGISTRAR'S SIGNATURE
Julia Davisson-Randall

1995

OCT

31

CERTIFICATE OF DEATH

95 33896 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 2. DATE OF DEATH 3. TIME OF DEATH VEAR 995 9:44a M 8. BIRTHPLACE (State or Foreign Washington DC 9c. COUNTY OF DEATH Prince Georges 10d. INSIDE CITY 1 TYES 2 NO 10g. CITIZEN OF WHAT COUNTRY? United States 14. RACE — American Indian, Black, White, atc. Specify: White 16b. KIND OF BUSINESS/INDUSTRY 20c. LOCATION — City or Town, State Clinton, Maryland Old Alexandria Ferry Road, Clinton, Md 20735 Interval Retwe Onset and Death 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PERFORMED? AMAILABLE PRIOR TO COMPLETION OF CAUSE 1 TYES 2 CHO OF DEATH? 1 | YES 2 | 10 28d. DESCRIBE HOW INJURY OCCURED 28I. LOCATION (Street and Number or Rural Route Number, City or Town, Stete) 29d. DATE SIGNED (Month, De

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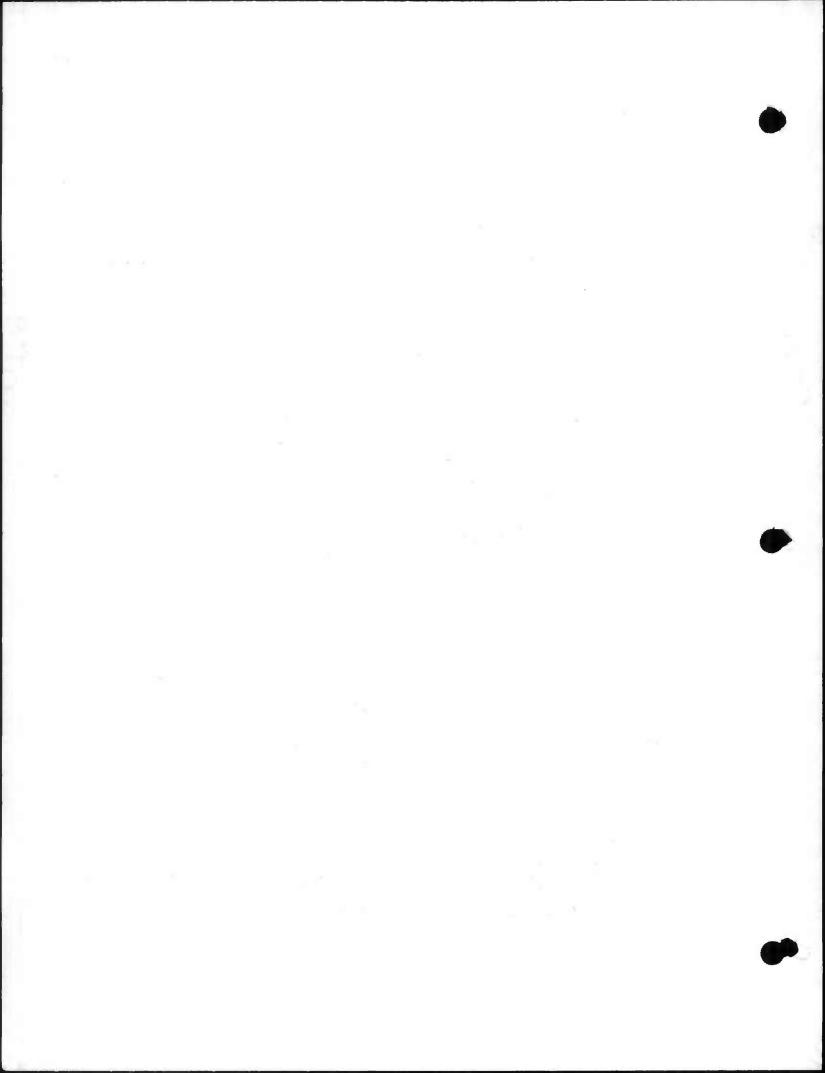
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	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or at	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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31. DATE FILED (Month, Day, Year)

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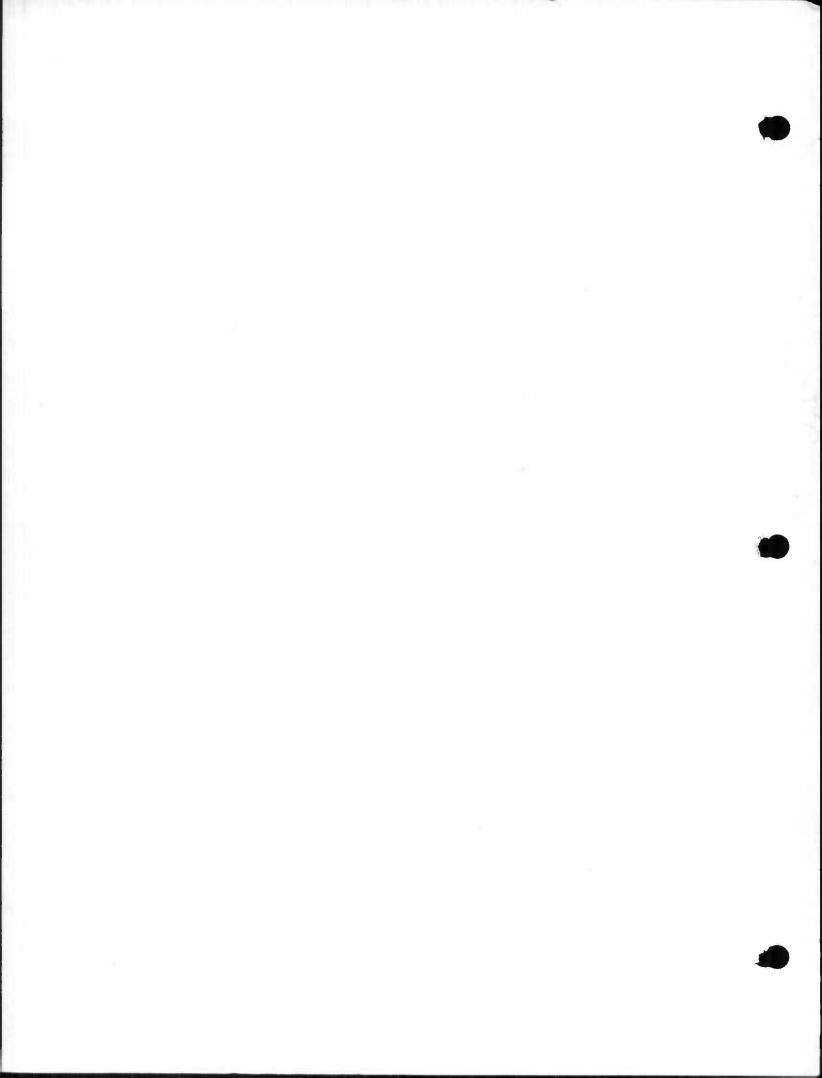
St. REGISTRATIS SIGNATURE
Julia Dhurlion Rardall

									95	3	3891
	1 - STATE REGISTRAR	STATE OF MAI	RYLAND /	DEPARTA ERTIFIC	MENT OF	HEALTH AND F DEATH	MENT	AL HYGIEN REG. NO.	E		
	1. DECEDENT'S NAME (First, Middle, Leat)	BE	Botel	er				E OF DEATH	5,19	7EAR 3	TIME OF DEATH
	4. SOCIAL SECURITY NUMBER 216-28-2362	1X M 2 - F	AGE (In yrs. les		UNDER 1 YEAR		(Mor	ch 15,		Country)	ACE (State or Foreign
OB		17300 Queen Anne Road			9b. CITY, TOWN OR LOCATION OF DEATH Upper Marlboro			ATH 9c. COUNTY OF DEATH			
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY Maryland Prince				own or Loc	arlboro				7	0d. INSIDE CITY LIMITS?
	10e. STREET AND NUMBER					10f. ZIP CODE	22				YES 2 X NO
BY FUNERAL	17300 Queen Anne Road 11. MARITAL STATUS 1			IMED NO		NIC ORIG	IN? (Specify Yee o Rican, etc.)	or No—	4. RACE - Black, \ Specify:		
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (9-12)				done during i	TION most of working	16	b. KIND OF BUS			asian
CMPL	8th N/A Carper				er Conti					elf	employed
	Robert Oswald Boteler Isabel Irene I						Padget				
2	196. INFORMANT'S NAME (Type/Print) Peggy A. Boone 196. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2210 Old Largo Road Upper Marlboro, Md 20772										
	206. NETHOD OF DISPOSITION 1 A guriel 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) 1. SIGNATURE OF JUNETAL SHAPE LICENSES 206. PLACE AND DATE OF DISPOSITION (Name of Ct. 28, DATE cemetery, crematory or other place) 1. SIGNATURE OF JUNETAL SHAPE LICENSES 206. LOCATION — City or Town, State cemetery, crematory or other place) 1. SIGNATURE OF JUNETAL SHAPE LICENSES 21. SIGNATURE OF JUNETAL SHAPE LICENSES 22. NAME AND ADDRESS OF FACILITY 1. Lee Funeral Home, 6633 Old Alexandria Ferry Rd Clinton								Maryland , Inc.		
	23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death disease or condition resulting in death)										
CENTIFICATION	DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):										
. 11	PART II. Other significant conditions	contributing to das	th but not r	asuiting in t	he underlyi	ng cause given in	Part I.	24s. WAS AN PERFOR 1 YES 2	MED?	AA CI	ERE AUTOPSY FINDINGS MILABLE PRIOR TO OMPLETION OF CAUSE F DEATH?
	DID TOBACCO USE CONTR	IBUTE TO CAUS	E OF DEA	TH YES	NO I	UNCERTAL	N 🗆			1	☐ YES 2 ☐ NO
THEOREM: MEDICAL		HOSPITAL:			THER:	o) ome 5 2 Residence	6 🗆 Oth	er (Specify)			
	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	28e. DATE OF INJU		28b. TIME OF	٧	JURY AT VORK? YES 2 NO	28d. DE	SCRIBE HOW IN	JURY OCCU	RED	1
	3 Suicide 8 Could not be determined	28e. PLACE OF IN. building, etc.	JURY — At ho (Specify)	me, farm, stree	t, factory, of	ice	281. LO C/t)	CATION (Street e or Town, State)	nd Number or	Rural Rout	te Number,
COMPLETED	29e. CERTIFIER (Check only one) 1 CERTIFYINO PHYSIC MEDICAL EXAMINER	IAN: To the best of my I : On the basis of examin									nd manner ee stated.
	296. SIGNATURE AND TITLE OF CENTIFIES LIGHTS TO	Lowings	ug 1	m		2/2	MBER 30		29d, DATE S	IGNED (M	onth, Day, Year) 26,1995
	HAME AND ADDRESS OF PERSON HIND COMPLETED CASE OF DEATH LITEM 271 (Typo. Print) THE STOP FOR STATE OF										
	31. DATE FILED (Month, Day, Year)	A. REGISTRAR'S	SIGNATURE	0 111	,		1	U			



be executed.	tian and completely filled in by the funeral director, page 5 should be detached for use as the burial	or to burial, cremation, or removal,	aumatic event, the medical examiner must be notified at once.
TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial. cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
IN IN	TO THE	be filed	IMPOR

	1 - STATE REGISTRAR	STATE OF MARYLAN	ID / DEPAR				MENTAL	HYGIENE				
	1. DECEDENT'S NAME (First, Middle, Lest) Earl Dougla	s BROWN					2. DATE OCLO	of DEATH ber 29	, 199	5 SEAR	1:10 PM M	
		SEX 6. AGE (In y 76	rs. last birthday) YRS.	IF UNDER 1		IF UNDER 24 HRS.	7. DATE	.16,19	919	s. BIRTH Countr Mai	ryland	
OR	96. FACILITY NAME (If not institution, give street 1631 Colonial Wa					own or location of death ederick				Frederick		
DIRECTOR	10e. STATE 10b. COUNTY Maryland Freder	ick	ck Frederic							10d. INSIDE CITY LIMITS? YES 2 NO		
FUNERAL	1631 Colonial Wa	у			10f. Z	21702	10g. CITIZEN U.S.A			ZEN OF V	VHAT COUNTRY?	
В	1 Name Married 2 XXMarried	was deceoent ever in u. forces? 1 \(\tilde{\Omega} \) yes if yes give war or date ept .28, 1939 Ser	2 NO	1 11		Ify Cuban, Maxica	n, Puerto Ricen, etc.) Black, \			E — American Indian, t, White, etc.		
COMPLETED	15. DECEDENT'S EDUCAT (Specify only highest grade con Elamentary/Secondary (0-12)	ollega (1-4 or 5 +)	Give kind of life. Do NOT us	se retired.)			16b.	US GOY				
	17. FATNER'S NAME (First, Middle, Last)			N		es. motner's na Ani			Surname)	-TOWAI	RD	
TO BE	19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1631 Colonial Way, Frederick, Maryland 21702									21702		
	207 NETHOD OF DISPOSITION 113 Ourlei 2 Cremetion 3 Removal 4 Donation 6 Other (Specify)	from State Cemera	ACE AND DATE	eneter	y, No	v. 2, 199		Free	deric		wn, State Maryland	
	21. SIGNATURE OF EUNEAL SERVICE LICENSE. Hi					ADDRESS OF FAC ks Fune: orest D:			polis	s, Mo	d. 21401	
	23. PART I. Enter the diseasea, or com shock, or heart failure. List IMMEDIATE CAUSE (Final disease or condition resulting in death)		h lina.						·		Approximate interval Batween Onset and Daath	
CERTIFICATION	Sequantially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated eventa resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE DF):											
PHYSICIAN: MEDICAL C	PART II. Other significant conditions c	ontributing to death but	not resulting	in tha und	dariying	causa givan in	Part I.	24a. WAS AN / PERFORI	MED?	246	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	
CIAN:	DID TOBACCO USE CONTRIB 25. WAS CASE REFERRED TO MEDICAL EXAMINER?		DEATH YI	TN (Check or	nly one)	UNCERTAIN	1 2					
PHYSI		Inpatient 2 ER/Outpatk 26e. DATE OF INJURY (Month, Day, Year)	28b. TIN		28c. INJUF WOR	K?		(Specify)	JURY OC	CURED		
TED BY	2 Accident investigation 3 Suicide 8 Could not be 4 Nomicide detarmined	26s. PLACE OF INJURY — building, atc. (Specify)	At home, ferm,	M t YES 2 NO			281. LOCATION (Street and Number or Rural Route Number, City or Town, State)				Route Number,	
COMPLETED	onel	N: To the best of my knowled on the basis of examination a									s) and menner as stated.	
TO BE C	29b. SIGNATURE AND TITLE 05 CERTIFIER	March.	7	29c. LICENSE NUM D 1819							(Month, Day, Year) r 30, 1995	
	Dr. Arthur G. Mar	nalo MD 187	Thomas	Johns	son I	rive, F	'rede	rick,	Mary	1and	21702	
	NOV 0 1 1995	32. REGISTRAN'S SIGNATURA	ure Rardall									



TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

29e. CERTIFIER (Check only one)

ours after death. Page 6 may be retained by the hospital or attending physician.	med in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, in, or removal.	he medical examiner must be notified at once.
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within purs after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this cardificate has been signed by the attending physician and completely med in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: Il tiem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

FOR										dinion.		10.00	
1 - STATE REGISTRAR		STATE OF N	IAHYLAN	D / DEPART CERTIFI					MENTA	REG. NO			
1. DECEDENT'S NAME (First	, Middle, Last)								2. DATE	OF DEATH			3. TIME OF DEATH
MARGARET	WA	LKER	BARNW	ELL					OCTO	BER 2	5, 19	95"	3:30 рм
4. SOCIAL SECURITY NUMBER	BER	5. SEX	6. AGE (In yr	s. last birthday)	IF UNDER		-	R 24 HRS.		OF BIRTH h, Day, Year)		8. BIRTHI	PLACE (State or Foreign
229-26-18	97	1 □ M 2 🔀 F	76	YRS.	MONTHS	DAYS	HOURS	MIN.	JAN	14,	1919	VIRG	INIA
9a. FACILITY NAME (If not in		street end number)			9b. CITY,	TOWN	OR LOCAT	ION OF D	EATH			INTY OF DE	
8 E. MAIN					THU	RMO	T				FR	EDERI	CK
10e. STATE	10b. COUNT	TY		10c. CITY	, TOWN O	R LOCAT	TION						10d. INSIDE CITY
MARYLAND	FRI	EDERICK		T	HÜRM	ONT							LIMITS7 1 X YES 2 NO
10e. STREET AND NUMBER						101	. ZIP CO	DE		_	10g. CIT	IZEN OF W	HAT COUNTRY?
8 E. MAIN	ST.						2178	8			U.:	S.A.	
11. MARITAL STATUS		12. WAS DECEDEN FORCES? 1								f? (Specify Yo	e or No-	14. RACE	- American Indian, White, etc.
1 Never Merried 2 3 Widowed 4 🖔 Divo		IF YES, GIVE V						Speci		mican, etc.)		Specif	y:
	EDENT'S EDI	ICATION		n. DECEDENT'S (101111 00	CLIDATI	201		1	. KIND OF BI			ITE
(Specify on	ly highest grad	e completed)		(Give kind of w life. Do NOT use	ork done d	uring mo	ist of work	ing	100	L KIND OF BI	Jameaa/IN	DUSTRY	
Elementary/Secondary (0-12)	College (1-4 or 5 -	•)	ORGAN	TST					MUSIC	1		
17. FATHER'S NAME (First, M	fiddle, Last)	3		Oligilit	101		18. MO	THER'S N	AME (First,	Middle, Maide		_	
ROBERT	CHAR	LES WA	LKER				E	TTA	LL	EWELYN	T	YLER	
19e. INFORMANT'S NAME (19b. MAILING									
DONALD L.	SPAL	DING		13703	STR	AFF	ORD	DR.,	THU	RMONT,	MD :	21788	
20e. METHOD OF DISPOSIT		MOVel from State	ott	ACE OF DISPOS								City or Tox	
4 Donation 5 Other	(S)90(f)		SMI	CHSBURG						0/26 5	MITH	SBURG	, MD
21. SIGNATURE OF FUNERO	L SERVICE L	CENSEE						DAI		SON	FUNE	RAL H	OMES, P.A.
1///										CHURMO			
23 FART I. Enter the d	Reases, or	complications the	caused th	e deeth. Do n	ot enter	the mo	da of d	ying, au	ch aa car	diac or rea	piratory a	rest,	Approximata Interval Batween
IMMEDIATE CAUSE (FI		Carlotty one con	ISS ON BACK	mro.	j.,	/	. 0		/				Oneat and Death
disease or condition	\rightarrow	Co	Nges	TIVE	17	CAR	4	11/	400	-			10 years
		DUE TO	(OR AS A CO	TIVE INSEQUENCE OF):								10
Sequentielly list condit	tions (b. CO/	LONAN	7 1	nn	7_	"	(Se	160				13 Yea 125
If any, leading to imme	diate	DUE TO	(OR AS A CO	NSEQUENCE OF):								
CAUSE (Disease or Inju		C. DUE TO	(OR AS A CO	NSEQUENCE OF	٦٠								
that initiated eventa resulting in death) LAS	ST .		(0.1.20.2.00	WOLGOLINGE OF	,.								İ
		d											
PART II. Other algnifica	7	ne contributing to		not resulting in	n the un	derlyin	g cause	given i	Part I.	24a. WAS A PERFO	N AUTOPSY	24b.	WERE AUTOPSY FINDINGS MAILABLE PRIOR TO
PINI	betts	121	2//1/	4)						1 TYES	2 X NO	11	OF DEATH?
													1 TYES 2 NO
		i											
25. WAS CASE REFERRED T EXAMINER?	TO MEDICAL	HOSPITAL:			OTHER		LACE OF	DEATH (C	heck only o	ne)			
1 TYES 2 NO		1 Inpatient 2				_		Residence	6 Oth				
	Pending	28e. DATE OF (Month, E		28b. TIME	E OF URY M	WC	URY AT ORK? YES 2	□ NO	28d. DE	SCRIBE HOW	INJURY O	CURED	
2 Accident 3 Suicide	Investigation	28e. PLACE C	F INJURY —	At home, farm, s					281. LO	ATION (Stree	t end Numbe	or Rural R	loute Number,
4 Homicide	Could not be determined	building,	etc. (Specify)						City	or Town, Stat	9)		

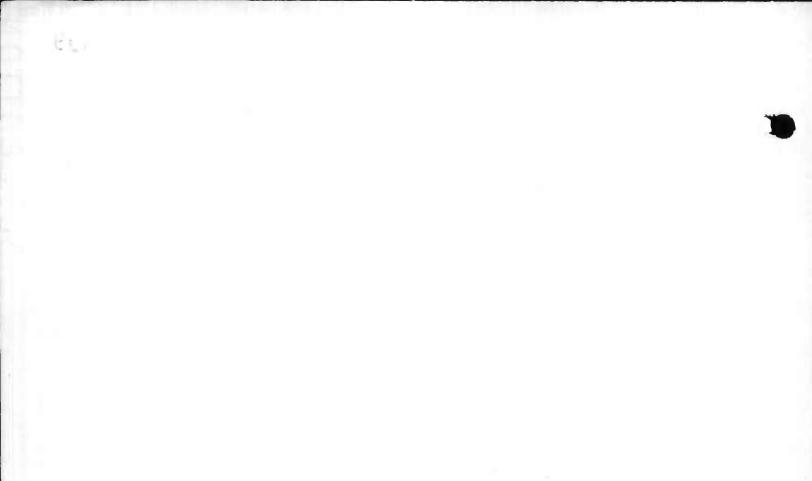
29b. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Day, Year) 29c. LICENSE NUMBER OCTOBER 26,

1 🗵 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end piece, end due to the ceuse(e) end menner ee stated.

2 MEDICAL EXAMINER: On the basis of exa

WILLIAM F. HARPER M.D. 100 S. CENTER ST., THURMONT, MD 21788

1995



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlat, cremation, or removal. IMPORTANT: If them 28 is marked, or them 23 shows any injury, or other traumatic event the markets avaining must be annitified at some	D THE HIGSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within X frours after death. Page 6 may be retained by the hospital or attending physician.	
		D THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 hours after death. Page 6 may be retained by the hospital or attending physician.

BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

2

4 Homicide

	FOR 1 - STATE REGISTRAR	STATE OF I	MARYLAND /	DEPAR RTIF	RTMENT	OF H	EALTH DEAT	AND I	MENTAL HYGI				
93	1. DECEDENT'S NAME (First, Middle, La	st)							2. DATE OF DEAT			3. TIME OF DEATH	
		BRYANT						Oct. 23, 1995			11:45 A M		
	4. SOCIAL SECURITY NUMBER			birthday)	IF UNDER 1	YEAR	IF UNDER	24 HRS.	7. DATE OF BIRTH 8. BIRT			HPLACE (State or Foreign	
- 6	226-07-9940	1 XM 2 - F	85	MONTHE			HOURS MIN. Sept. 25			, 191	1910 Virginia		
	9a. FACILITY NAME (If not institution, given	e street and number)			9b. CITY,	TOWN O	R LOCATIO	ON OF DE	ATH	9c. CO	UNTY OF D	DEATH	
DIRECTOR	Frederick Memori		al		Fred	leri	ck			Fr	Frederick		
입	10a, STATE 10b, COU			10c. CIT	TY, TOWN OF	LOCAT	ON					10d. INSIDE CITY	
	Maryland Fre	ederick		Fre	deric	ck						LIMITS?	
A	10s. STREET AND NUMBER					10f.	ZIP CODE			10g. C	TIZEN OF	WHAT COUNTRY?	
FUNERAL	8519 Rocky Springs Road						2170	1			U.S	S.A.	
5	11. MARITAL STATUS 12. WAS DECEDENT EVE FORCES? 1 V Y			AED	13. W	AS DECI	NDENT O	F HISPAN	IIC ORIGIN? (Specify	Yes or No-	14. RAC	E — American Indian, ck, White, etc.	
BY	1 Never Married 2 A Married 3 Widowed 4 Divorced	MAR OR DATES		1	YES	2 NO	Specify	n, Puento Hican, etc.	}	Spec	-thv:		
	3 Wildowed 4 Divorced WWII									White			
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) (in Decedent (in Decedent (in Decedent Dec					CUPATIO	N t of working	9	16b. KIND OF	BUSINESS/II	IDUSTRY		
ا ۳	Elementary/Secondary (0-12)		_										
₹	12 years Government Employee None												
8	17. FATHER'S NAME (First, Middle, Last)								ME (First, Middle, Me	iden Surname)			
BE	Harry Bryant Lucy Emory												
2						(Street ar	d Number	or Rural F	Route Number, City or	Town, State, 2	(ip Code)		
-	Hazel M. Bryant 8519 Rocky Springs Road Frederick, Mary							land 21701					
	20a. METHOD OF DISPOSITION	20b. PLACE A	b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State							own, Sista			
	1) Buriel 2 Cremetion 3 Re 4 Donation 5 Other (Specify)		Blanfo	ery. grematory or other place) Miford Cemetery 10/26 Petersburg, Virgin:							Virginia		
- 1	21. SECHATURE OF FUNELAY SERVICE LENSEE 22. NAME AND ADDRESS OF FACILITY ROBERT E. DAILEY & SON FUNERAL HOMES, P.A.												
- 1	1 (Kolity	Bill	21/1									•	
\neg	23 PAUT I Enter In the		VK	45 0	1120) I N	ORTH	MAR	KET ST.	FREDE	RICK,	MD 21701	
	23. PART i. Enter the diseases, cahock, or heart fallur	e. List only one cau	ise on each line.	ith. Do	not enter t	he mod	le of dyli	ng, suci	h aa cardiac or n	apiratory a	rreat,	Approximata interval Between	
	IMMEDIATE CAUSE (Final disease or condition	Λ	1		1 =	. /	,	,	•			Onset and Death	
	resulting in death)	. Hen	e my	nea	ulal	V	Wood	use	con			new mits.	
		DUE TO	(OR AS A CONSEC	UENCE O	F):		1						
Z	Sequentially flat conditions,	b. 10	OR AS A CONSED		cure	14	de	rea	se			years.	
Ĕ	if any, leading to immediate	DUE TO	(OR AS A CONSED	UENCE O	F):	1						0	
2	CAUSE (Disease or injury												
#	that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST												
CERTIFICATION	d.												
	PART II. Other aignificent conditi	ona contributing to	death but not re	sulting	in the und	erivica	COULOR	lunn in	Dart I Die line	AN AUTOPSY		WERE ALTERNATION OF THE STATE O	
ICAL		elouda.					oense g	. 7011 111	PER	FORMED?	246	MAILABLE PRIOR TO COMPLETION OF CAUSE	

//	Louday is Chan		24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 YNO	24b. WERE AUTOPSY FINDIN AMAILABLE PRIOR TO COMPLETION OF CAUSI OF DEATH? 1 YES 2 NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEATH (C	theck only one)	
1 VES 2 NO	1 Inpatient 2 ER/Outpatient 3 DOA	4 - Nursing Nome 5 Residence	6 Other (Specify)	
27. MANNER OF DEATN 1 Netural 5 Pending 2 Accident Investigation	28e. DATE OF INJURY (Month, Dey, Year)	ME OF 28c. INJURY AT WORK? M 1 YES 2 NO	28d. DESCRIBE NOW INJURY OCC	URED
3 Suicide 6 Could not be	26s. PLACE OF INJURY — At home, lerm, building, atc. (Specify)	street, factory, office	28f. LOCATION (Street and Number of City or Town, State)	or Rural Route Number,

29a. CERTIFIER (Check only one)

29b. SIGNATURE AND TITLE O 29d. DATE SIGNED (Month, Day, Year)

D-18063

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 801 Toll House Avenue Frederick, Maryland 21701 A Majeed MD,

31. DATE FILED (Morith, Day, Year) 32. REGISTRAMS SIGNATURE PORTALL 1995

10

BALTIMORE, MARYLAND 21215-0020	L DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	money and the production has been decould be the released on the formal dispersion of the buried broads of
	ours a	in he
6	24 h	, fillan
DIVISION OF VITAL RECORDS, P.O. BOX 68760	requires that the death certificate be executed within	and along the opposition of the contract of the contract of
DIVISION OF VITAL F	DR ATTENDING PHYSICIAN: The law in	the second section of the contract of the second section in

ansit permit. Pages 1, 2, 3 should TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the attending physician and completely filled in by the funeral director, page 5 should be detache be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	FOR STATE REGISTRAR	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND CERTIFICATE OF DEATH	MENTAL HYGIENE REG. NO.
1.	DECEDENT'S NAME (First, Middle, Last)		2. DATE OF DEATH

- STATE REGISTRAR	STATE OF MARTIL		ICATE O	F DEATH	MENIAL HYGIE REG. N				
1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH MONTH	DAY YE	3. TIME OF DEATH		
	tanley Buch			1	Oct. 26	1995	8:10 P		
4. ROCIAL SECURITY NUMBER 213-44-1171	5. SEX 6. AGE (In yrs. last birthday)	MONTHS DAYS		(Month, Day, Year) June 1,	10//	BIRTHPLACE (State or Foreign Country)		
		YRS.				1944	Maryland		
Se. FACILITY NAME (If not institution, give	street and number)		9b. CITY, TOW	N OR LOCATION OF D	EATH	9c. COUNTY	OF DEATH		
Salisbury Nursing	& Rehab Cent	er	Salis	oury. Md.		WICON	4ICO		
10e. STATE 10b. COUNT	Υ	10c. CIT	TY, TOWN OR LO	CATION			10d. INSIDE CITY		
Maryland	Dorchester		East	New Ma	rket		LIMITS?		
10e. STREET AND NUMBER				101. ZIP CODE	I NOU	OF WHAT COUNTRY?			
5634 Mt. Holl	y Road			21631			US		
11. MARITAL STATUS 1 Never Merried 2XX Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER II FORCES? 1 YES IF YES, GIVE WAR OR O	2 X NO	If yes,	ECENDENT OF HISPA specify Cuben, Mexic ES XXNO Speci	NIC ORIGIN? (Specify an, Puerto Rican, etc.)	fee or No— 14.	RACE — American Indian, Black, White, etc. Specify: White		
16. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working									
Elementary/Secondary (0-12)	College (1-4 or 5+)	IIIe. Do NOT u	use retired.)						
12	4	License	ed Pract	ical Nurs	se Heal	th Care			
17. FATHER'S NAME (First, Middle, Last)					AME (First, Middle, Maid	en Sumame)			
George Stanley				Bess	sie Smith				
19e. INFORMANT'S NAME (Type/Print)					Route Number, City or 1				
John H. Buchanar							laryland 2163		
200. METHOD OF DISPOSITION 1 XI Burlai 2 Cremation 3 Removal from State 4 Donalion 5 Other (Specify) 205. PLACE AND DATE OF DISPOSITION (Name of competery, crematory or other place) East New Market Cemetery 10/29 East New									
4 Donalion 5 Other (Specify)		East New				ast New	Market, Md.		
21. SIGNATURE FUNERAL SERVICE L	CENSEE		Thom		1 Home, P		yland 21613		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	b	A CONSEQUENCE O			ignas		yes.		
that initiated events resulting in death) LAST	DUE TO (OR AS A	A CONSEQUENCE O	OF):						
PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert i. 246. WAS AN AUTOPSY PERFORMED? 1 YES 2XX NO							24b. WERE AUTOPSY FINDIN AMAILABLE PRIOR TO COMPLETION OF CAUS OF DEATH? 1 YES 2 NO		
DID TOBACCO USE CONT	TRIBUTE TO CAUSE O	OF DEATH Y	ES NO	☐ UNCERTA	INXX				
25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL: 1 Inpetient 2 ER/Out	26. PLACE OF DE	OTHER:		8 Other (Specify)				
27. MANNER OF DEATH 1 Antural 5 Pending Investigation	28e. DATE OF INJURY (Month, Day, Year)	28b, Ti	ME OF 28c.	INJURY AT WORK?	28d. DESCRIBE HO	W INJURY OCCUI	RED		
2 Accident 3 Suicide 6 Could not be determined	28e PLACE OF INJUST	Y — Al home, ferm.	, street, fectory, c	ffice	281. LOCATION (Stre City or Town, St	et and Number or ate)	Rural Route Number,		
(Check only	SICIAN: To the best of my know IER: On the basis of examination								
29b. SIGNATURE AND TITLE OF CENTURE	110			29c, LICENSE N	UMBER	29d. DATE S	SIGNEO (Month, Day, Year)		
11/0	16/			0	7349	1	1/31/85		
30. NAME AND ADDRESS OF PERSON W	HO COMPLETED CAUSE OF DE	EATH (ITEM 27) (Typ	oe, Print)		1		/ /		
William Robbins,	M.D. 110	4 HEALTH	WAY DR	, SALISBU	JRY, MD.	21801			
31. DATE FILED (NOV 01 19	95 32. REGISTRANE, SIGN	NATURE PONT	V.						
140 1 0 1 13	July mills	MAN AMACH	4						

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PRICE OF A

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTION After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 Is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPARTM CERTIFIC			IENTAL HYGIEN					
	1. DECEDENT'S NAME (First, Middle, Las	t)				2. DATE OF DEATH		3. TIME OF OEATH			
	ALVIN	BATTLE				October 1		5:10 a м			
	4. SOCIAL SECURITY NUMBER	5. SEX 8. AGE (In yrs. last birthday) #	UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	9. BIR	THPLACE (State or Foreign			
	566-38-6061	1X M 2 F	81 YRS. MO	NTHS DAYS	HOURS MIN.	(Month, Day, Year) July 29,		elmar, Texas			
	9a. FACILITY NAME (If not institution, give	atreet and number)	91:	. CITY, TOWN O	R LOCATION OF DEA		9c. COUNTY OF				
e e	Mediplex Nur	sing Home		Ga	ithersbu	ra	Mon	t a am a sec			
DIRECTOR	RESIDENCE OF DECEDENT 10e. STATE 10b. COUN					1.8	HOU	tgomery			
쁘				OWN OR LOCATI				10d. INSIDE CITY LIMITS?			
	Maryland Pr	ince George's		Temple				1 YES 2 NO			
FUNERAL	1905 Gaith	0.		10f.	ZIP CODE		10g. CITIZEN OF	WHAT COUNTRY?			
N N	1903 GAITH	12. WAS DECEDENT EVER IN			20748			d States			
	1 Never Married 2 Married	FORCES? 1 TYES	2 NO	If yes, spe	offy Cuban, Maxican,	C ORIGIN? (Specify Yes Puerto Rican, etc.)	or No — 14, RA Bis	CE — American Indian, ick, While, atc.			
ВҰ	3 X Widowed 4 Divorced	IF YES, GIVE WAR OR DA	NTES	1 TYES	2 NO Specify:		Spi	D11-			
ED	15. DECEDENT'S ED	DUCATION	16a. DECEDENT'S USU	JAL OCCUPATIO	N	16b, KIND OF BU	SINESS/INDUSTRY	Black_			
H	(Specify only highest gra	Coffege (1-4 or 5+)	(Give kind of work life. Do NOT use re	done during mos tired.)	t of working						
AP.		5+	Trainin	ng Spec	ialist	G	overnme	nt			
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				16. MOTHER'S NAM	E (First, Middle, Maiden					
BE (Henry B	attle			Ra	chel McDo	nald				
5	19a. INFORMANT'S NAME (Type/Print)					oute Number, City or Tow					
1	Helen Battle	Jones	1905	Gaithe	St., Te	mple Hill	s, MD	20748			
	20a. METHOD OF DISPOSITION 1 String 2 Cremetion 3 Re	moval from State 20b.	PLACE AND DATE OF D	SPOSITION (Ner	ne of	OATE 20c. LO	CATION - City or	Town, State			
0.0	4 Donation 5 Other (Specify)		Lincoln Memor	rial Ceme		/23/95	Suitla	nd, MD			
	21. SIGNATURE OF FUNERAL SERVICE I	CENTRE		22. NAME AN	O ADDRESS OF FACI	Stewar	t Funera	1 Home			
	10mm	Stlivon,	11	4001	Benning			D.C. 20019			
	23. PART I. Enter the disesses, or	complications that caused b. List only one cause on e	the deeth. Do not	enter the mod	le of dying, such	ss cerdiac or respi	ratory srrest,	Approximate			
	IMMEDIATE CAUSE (Final	- 10 Mar 10 T						Interval Batween Onset and Death			
	disease or condition resulting in death) a. Due to (or as a consequence op): MENTALL Stoppe Course Our TO (OR AS A CONSEQUENCE OP): Our TO (OR AS A CONSEQUENCE OP):										
	DUE TO (ON AS A CONSEQUENCE OF):										
N	Sequentielly list conditions,	· METHOR	Mu Ile	1119en	ice Sto	pro Cum	EUD CUP				
CERTIFICATION	if any, leading to immediate	OUE TO (OR AS A	CONSEQUENCE OF):			1					
2	cause. Enter UNDERLYING CAUSE (Disease or Injury	C. DUE TO OR AS A	COMPECULIANE OF								
	that initiated events resulting in death) LAST	DOE TO (ON AS A	CONSEQUENCE OF):								
Ü		d									
AL (PART II. Other significant condition	ons contributing to deeth be	ut not resulting in ti	he underlying	ceuse given in P			b. WERE AUTOPSY FINDINGS			
5						PERFOR		AVAILABLE PRIOR TO COMPLETION OF CAUSE			
MEDIC							X	OF DEATH? 1 YES 2 NO			
ž	DID TOBACCO USE CON	TRIBUTE TO CAUSE O	F DEATH YES		UNCERTAIN			La Lori			
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF OEATH (C								
S	1 TYES 2 NO	1 - Inpatient 2 - ER/Outp		HER: Nursing Home	5 - Residence 6	☐ Other (Specify)					
H	27. MANGKER OF DEATH	28a. DATE OF INJURY (Month, Are: War)	386. TIME OF	25c. INJU WOR	RY AT	284. DESCRIBE HOW H	NJURY OCCURED				
В	2 Accident S Pending			M IIIW	ts 2 NO						
8	3 Suicide 6 Could not be 4 Homicide determined	28e, PLACE OF INJURY building, etc. (Speci	At home, farm, street	t, factory, office		181. LOCATION (Street a City or Reen, Street)	and Mumber or Ruse	Route Number			
E	4 Hamicide determined					27/1/12/12/15					
COMPLET	ner as stated.										
O	One) 2 MEDICAL EXAMIN	NER: On the basis of examination	and/or Investigation, In	my opinion, de	ath occured at the tir	me, data and placa, an	d due to the cause	(a) and manner as stated.			
BE C	29K SIGHATURE AND TITLE OF CERTIF	ER			29c. LICENSE NUMB	55、	29d. DATE SIGNI	D (Mary Day, Year)			
	NEX	Λ			1306	XL	10/	10/75			
5	30. HAME AHE ADDRESS OF PERSON W	HO COMPLETED CAUSE OF DE	de l	(1)	0	0	1	0-5/5			
1	CYA BORIU	FOI 1110	288VD2	Java	KUDAD	Nocum	KE.UI	15810			
	OCT 27 1995	32 AEGISTHAR'S SIGNA	ATURO ATURO	0							
	001 21 1955) James av aurage									

DALLIMORE, MARTLAND	hours after death. Page 6 may be retained by the hosp	d in by the funeral director, page 5 should be detached	or removal.	medical examiner must be notified at once.
CHARLES OF THE TECONES, F.O. BOA 681 60	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hosp	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	TATE OF MARYLA	ND / DEPAR	TMENT	OF H	EALTH DE AT	AND I		YGIENI EG. NO.	8		
1	1. DECEDENT'S NAME (First, Middle, Last)		OLITIN	IOATE	- 01	DLAI		2. DATE OF D	EATH			3. TIME OF OEATH
	MATILDA A. BOVA							OCTOB1	ER 1		YEAR 195	8:00 P. M
	4. SOCIAL SECURITY NUMBER 5. S	EX 6. AGE (In	yrs. lest birthday)	IF UNDER		IF UNDER		7. DATE OF B	IRTH	7	8. BIRTNI	PLACE (State or Foreign
	217-07-0510	^{™ 2} 🐰 F 84	YRS.	MONTHS	DAYS	HOURS	MIN.	AUG. 2		911	Country	rvland
-	9a. FACILITY NAME (If not institution, give street ar	nd number)		9b. CITY	TOWN C	R LOCATIO	ON OF DE		,, _		TY OF DE	
DIRECTOR	5612 Newton Street			Н	yatt	svil	le			Pri	ice (George's
EC	10a. STATE 10b. COUNTY		10c. CIT	Y, TOWN C	R LOCAT	ION						10d, INSIDE CITY
DIA	Maryland Prince	George's	HA	attsv	, , 11	0						LIMITS? 1 YES 2 V NO
	10e. STREET AND NUMBER	George 3	1 11 9	acts	-	. ZIP CODE				10g. CITI	ZEN OF W	HAT COUNTRY?
FUNERAL	5612 Newton Street					2078	84		- 1	Unit	-04 0	States
5	11. MARITAL STATUS 12. V	MAS DECEDENT EVER IN U	.S. ARMED	13.	NAS DEC	ENOENT O	F HISPAN	NIC ORIGIN? (Sp	ecify Yes		14. RACE	- American Indian.
BY F	1 Never Merried 2 X Merried 3 Widowed 4 Divorced	FORCES? 1 YES	S XINO		Yes, spe	ecify Cubar 2 ₩ NO	n, Mexica Specifi	in, Puerto Rican y:	, etc.)		Specif	
												White
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade complete)	eted)	6a. DECEDENT'S (Give kind of a life. Do NOT us	work done o	CUPATIO	ON st of workin	g	16b, KINI	OF BUS	INESS/IND	USTRY	
7	Elementary/Secondary (0-12) Coll	lege (1-4 or 5+)	Millin					D		D		
MO	17. FATHER'S NAME (First, Middle, Last)		LITITIO	21		18 MOTA	IED'S NA	ME (First, Middle		Busi	lness	
	Walter Hammerschmid	t						Blume	, Maiden S	umame)		
BE	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADORESS	(Street a			Route Number, C	ity or Town	Stelle Zin	Codel	
2	Vincent F. Bova, Sr											d 20784
	20a. METNOD OF DISPOSITION	20b. P	LACE AND DATE	OF DISPOS			, 11	OATE				
	1 X Burial 2 Cremation 3 Removal fr 4 Donation 5 Other (Specify)	rom State cemete	ort Line	ther place)	Cem	eterv	7 10	/21/95	Brei	itwoo	d. M	laryland
	21. SIGNATURE OF FUNERAL SERVICE LICENSE	E		22.1	NAME AN	O ADDRES	S OF FA	CILITY				ide y zana
	1 /Lam	Dut						Funeral				MD 20722
	23. PART I. Enter the diseeses, or compl	ications that caused t	ha death. De r	ot antar	tha mod	de of dyi	ng, suc	h as cardiac	or respir	etory arn	est.	Approximate
	shock, or heart fellure. List of IMMEDIATE CAUSE (Final	only one cause on eac	h line.									Interval Between Onset and Death
	disease or condition . CEDCTC											MONTHS
	resulting in death) / a	DUE TO (OR AS A C	ONSEQUENCE OF	F):								HOWING
Z	C 6.	BREAST CANO	ER WITH	H MET	AST	ASIS						YEARS
SE	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A C	ONSEQUENCE OF	F):								
2	CAUSE (Disease or injury	DUE TO LOD AS A G										
Ē	that initiated events resulting in death) LAST	DUE TO (OR AS A C	ONSEQUENCE OF	-):								i
CERTIFICATION	d											
A	PART II. Other significant conditions con			n the un	dariying	cause g	Ivan in		WAS AN A		24b.	WERE AUTOPSY FINDINGS
PHYSICIAN: MEDIC	ANEMIA, HYPERTENSI	ON, CACHEXI	<u>A</u>						YES 2			AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
ME												1 TES 2 NO
ÿ	DID TOBACCO USE CONTRIBU	TE TO CAUSE OF	DEATH YE	S 🗆 1	40 🗆	UNC	ERTAIN	V 🗆				
CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	28 SPITAL:	PLACE OF OEAT	N (Check o								
YSI	1 YES 2 NO 1 -	Inpatient 2 - ER/Outpati	ent 3 🗆 DOA	4 Nurs	ing Nome	5 X Res	sidence	6 - Other (Spe	ictfy)			
F	27. MANNER OF DEATN 1 😿 Natural 5 🗌 Pending	28e. DATE OF INJURY (Month, Day, Year)	28b, TIM	E OF URY	28c. INJU WO	RK?		28d. OEŞCRIB	E HOW IN	JURY OCC	UREO	
B	2 Accident Investigation			M		ES 2	NO					
	3 Suicide 8 Could not be 4 Nomicide determined	28e. PLACE OF INJURY — building, etc. (Specify)	At home, lerm, s	dreet, facto	ory, office			281, LOCATION City or Tow	l (Street ar rn, State)	nd Number	or Rural Ro	oute Number,
COMPLETED	29a CERTIFIER											
MP	(Check only CERTIFYING PHYSICIAN:											
S		trie basis of examination a	nd/or investigatio	n, in my o	pinion, de	ath occur	ed at the	time, date and p	place, and	due to the	cause(a)	and menner as stated,
BE	296. SIGNATURE AND TITLE OF CERTIFIER	(V)	,			29c. LICE		4BER		29d. DATE	SIGNED	(Month, Day, Year)
2	20 NAME AND ACCOUNTS	, La 10	سي	4		D296	571			00	CT. 2	20, 1995
	30. NAME AND ADDRESS OF PERSON WHO COM											
	VILLAMOR S. REYES,			ER R	OAD,	CHE	VERI	LY, MAR	YLAN	D 2	0785	
	OCT 23 1995	REGISTRAR' SIGNATI	U.									

BALTIMORE, MARYLAND 21215-0020

BALTIMORE, MARYLAND 21215-0020	Nours after death. Page 6 may be retained by the hospital or attending physician.	s certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should ith the State Dept. of Reath and Mental Hygiene prior to burial, cremation, or removal.	e medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760.	TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with cours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the f be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

1	-	FOR STATE REGISTR	AR
,	1. D	ECEDENT'S	NA
1	7	Home	2

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CE	RTIFIC	ATE OF	DEATH		REG. NO).				
-	1. DECEDENT'S NAME (First, Middle, Last)							OF OEATH			3. TIME OF DEATH		
	THOMAS RANDOLY	DH .	BRU	ILS			MONTH	20	1995	YEAR	11:45 A		
	4. SOCIAL SECURITY NUMBER		AGE (In yrs. last		UNDER 1 YEAR	IF UNDER 24 HRS.	7. OATE	OF BIRTH	((1)	8 BISTU	PLACE (State or Foreign		
	579-40-6318	1 🖟 M 2 🗌 F	79		NTHS DAYS	HOURS MIN.	(Month	st 2,	1916	Nor	th Carolina		
_	9a. FACILITY NAME (If not institution, give s	treet and number)		-91		OR LOCATION OF D	EATH		1,00	NTY OF D			
DIRECTOR	Vantage Health				Colu	ımbia			H	lowar	d		
E I	10a. STATE 10b. COUNTY	10b. COUNTY 10c. CITY, TOWN OR LOCATION									10d. INSIDE CITY		
E I		ward		Columbia					t X YES 2 NO				
ERAL	100. STREET AND NUMBER 5400 Vantage Poi	nt Road		101. ZIP CODE 21044					10g. CITIZEN OF W				
BY FUNERAL	1t. MARITAL STATUS 1 Never Merried 2 Married 3 Divorced	12. WAS DECEDENT EX FORCES? 1 [X] IF YES, GIVE WAR	YES 2 NO		If yea, ap	ENDENT OF HISPA ecify Cuban, Mexica 2 NO Specific	an, Puerto F	? (Specify Ye lican, etc.)	e or No	14. RACE Black Specifi	- American Indian, white, atc.		
	15. DECEDENT'S EDU	CATION	16a. DEC	EDENT'S USI	JAL OCCUPATION	ON	16b.	KIND OF BU	SINESS/INI	DUSTRY			
Li I	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	(Giv.	s kind of work Do NOT use re	done during mo tired.)	st of working							
M M		, 7 _r		J	udge		Di	stric	t Co	urt c	of Maryland		
E COMPLETED	17. FATHER'S NAME (First, Middle, Last) Thomas Ransell Bi	rooks				Worthle				ings			
BE (19a, INFORMANT'S NAME (Type/Print)		196.	MAILING AD	DRESS (Street a	nd Number or Rural	Route Numb	er. City or You	yn, State, Zic	Code!			
2	Frances Brooks		54	00 Va	ntage	Point Ro	ad #6	09 C	oluml	oia,	MD 21044		
	20a. METHOD OF DISPOSITION 1 □ Burlel 2 ☒ Cremation 3 □ Ram 4 □ Donation 5 □ Other (Specify)	oval from State	cometany crea	atom or other	ISPOSITION (Ne	med natory 10	DATE		exand				
Ì	21. BIGNAZUME OF PUNERAL SERVICE LIC	ENSEE	Metrop	OTILL	22. NAME AL	ID ADDRESS OF FA	CILITY						
	> Hemy 8	. Fund				is Gasch Baltimor					MD 20781		
	23. PART I. Enter the diseases, or o	omplications that ca	used the dea	th. Do not	antar tha mo	da of dylng, suc	h aa card	isc or resp	iratory an	reat,	Approximata		
1	shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition	la .	-			.)					Onset and Death		
	disease or condition resulting in death) a. Masmic Line Camus Camus Sulls DUE TO (OR AS A CONSEQUENCE OF):												
_	CARININ tomound and to Lucy concern 34th												
CERTIFICATION	disease or condition resulting in death) a. Mys. mr. Lucy Camush Due to (or as a consequence of the same and the same an												
SE	CAUSE (Disease or Injury that initiated events	DUE TO (OR	AS A CONSEQU										
E	resulting in death) LAST	d									į		
	PART II. Other algnificant condition	a contributing to day	ath but not re	aulting in t	ne undarivin	cause given in	Part I	24s. WAS AN	AUTOREY	246	WERE AUTOPSY FINDINGS		
MEDICAL		_			io andarijini	dade given in	1 411	PERFO	RMED?	240.	AVAILABLE PRIOR TO COMPLETION OF CAUSE		
9							_	1 TYES	NO		OF DEATH?		
≥	DID TOBACCO USE CONTI	RIBUTE TO CAUS	E OF DEAT	H YES		UNCERTAI	NYG				1 TES 2, NO		
Y	25. WAS CASE REFERRED TO MEDICAL	ELECTION CAUS			Check only one)	ONCERIAI	4 br						
Sic	1 YES 2 NO	HOSPITAL:	/Outpetlant 3 「		HER:	e 5 ☐ Residenca	6 Other	(Spenify)					
PHYSICIAN:	27. MANNER OF DEATH	28s. DATE OF INJ	URY	26b. TIME OF	28c. INJ	URY AT		(Specify)	NJURY OC	CURED			
ВУ Р	1 Natural 5 Pending Investigation	(Month, Day, Y	ear)	INJURY	WO	RK? 'ES 2 NO							
- 41	2 Accident investigation 3 Suicide 6 Could not be determined determined control of the determined d									or Rural A	oute Number,		
	29s. CERTIFIER		33 31										
COMPLETED	(Check only 1 E CERTIFYING PHYSIC	CIAN: To the best of my li R: On the basis of exami-									end manner ea stated.		
	296 SIGNATURE AND TITLE OF CERTIFIER					29c. LICENSE NUI		4	_		(Month, Day, Year)		
BE 0	Sto Mhoous					D-	3486	8	▶ 6	ut Z	0,1945		
5	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE O	F DEATH (ITEM	A	mlain	0	.0		24140	7	11111		
	31. DATE FILED (Month, Day, Year)	32. AEGISTRAP'S	STENATURE	1 11	(}	our	WA	VW	01	7 7		
	OCT 23 1995	galia do los	BUSY NAM	Tally									



DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR STATE REGISTRAR 1

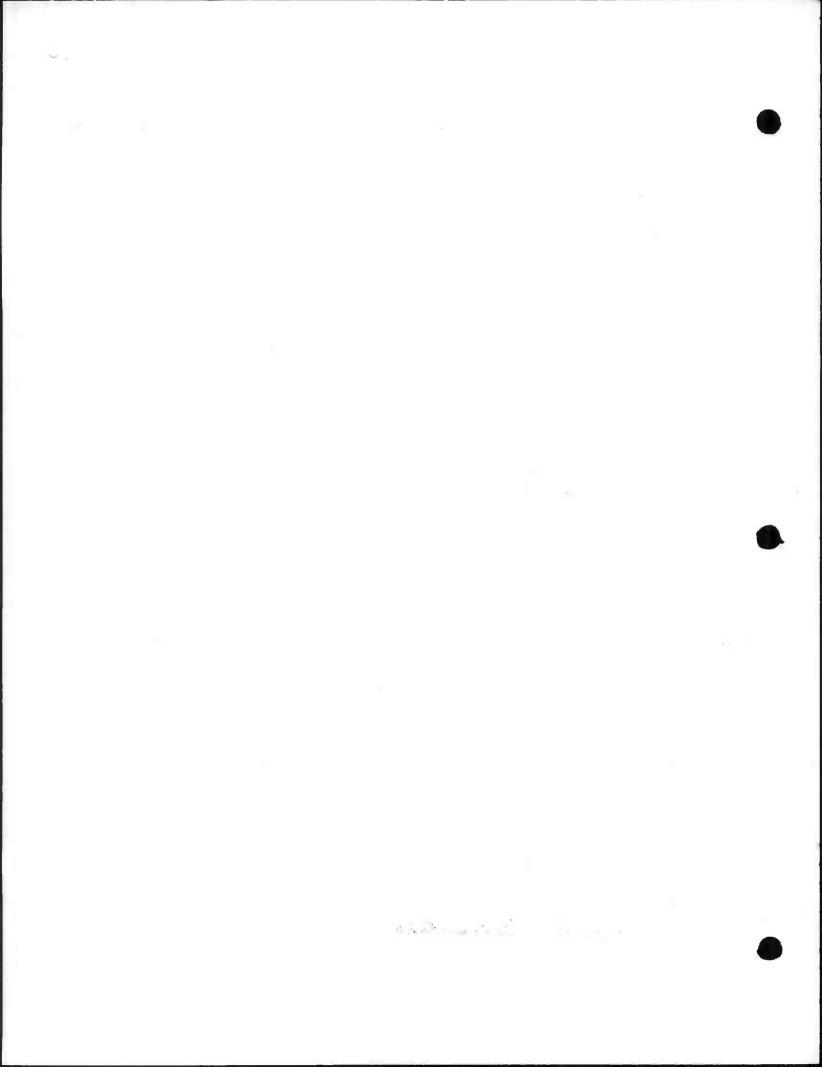
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

_				OFFILL	IIVAI	LUI	DLAIII		HEG. NO.			
ĺ	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE C		3. TIME OF DEATH			
	PHILIP ANTHON	Y BAT	SON					MONTH	ber :		1995 8:07 P	
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yr	s last hirthda	A DE LIMITE	R 1 YEAR	IF UNDER 24 HRS.	7. DATE O		17, 1	8. BIRTHPLACE (State or Foreig	
	578-76-0554	1 ☑ M 2 ☐ F	34	YRS.	MONTHS	DAYS	HOURS MIN.	(Month,	Day, Year)		Country)	
	9a. FACILITY NAME (If not institution, give s	**	34	ins.	June 1				18,		Washington, D).C.
~	13301 Central Ave						OR LOCATION OF D	EATH			JNTY OF DEATH	
DIRECTOR		nue			Upp	er M	arlboro			Pri	nce George's	
ត្ត	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY	,										
<u>E</u>		e George	1 0	10c. CITY, TOWN OR LOCATION							10d. INSIDE CITY LIMITS?	
		ocorge		Upper Marlboro							1 TYES 2 NO	
₹١	100. STREET AND NUMBER			101. ZIP CODE						10g. CIT	IZEN OF WHAT COUNTRY?	
FUNERAL	13301 Central Ave	nue		20772							U.S.A.	
5	11. MARITAL STATUS	12. WAS DECEDENT			13.	WAS DEC	ENDENT OF HISPAI	NIC ORIGIN?	(Specify Yes	or No-	14. RACE — American Indian.	
	1 X Never Married 2 Married	FORCES? 1 IF YES, GIVE W		⊠ NO		If yes, sp	ecify Cuban, Mexica 2 NO Specifi	in, Puerto Ri	can, etc.)		Black, White, etc.	
B	3 Widowed 4 Divorced		AIT OIT DATES			1 🗌 169	2 M NO Specif	у:			Specify: White	1.0
ᇜᅵ	15. DECEDENT'S EDUC		16a	. DECEDENT	'S USUAL C	OCCUPATIO	ON	16b. /	UND OF BUS	UNESS/INI	DUSTRY	-
COMPLETED	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+		(Give kind o	f work done use retired.)	during mo	st of working					. 4
2	12	College (1-4 or 5+	' I	Lith	nogra	pher		P	rinti	ng ar	nd Photography	У
8	17. FATHER'S NAME (First, Middle, Last)					Pitter			_			
	Paul Anthony Bats	on					16. MOTHER'S NA			Sumame)		
H							Patrici					
ဍ	19a. INFORMANT'S NAME (Type/Print)			19b. MAILIN	G ADDRES	S (Street a	nd Number or Rural	Route Numbe	City or Town	n, State, Zij	p Code)	
-	Paul Anthony Bats	on		13301	Cen	tral	Ave. Up	per M	arlbo:	ro, N	MD 20772	
	20s, METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Remo	uml danne State	20b. PLA	CEANDDAT	E OF DISPO	SITION (Na	me of	OATE	20c. LO	CATION -	City or Town, State	
1	4 Donation 5 Other (Specify)	JARI LIGHT STREE	/, crematory or other place						er Spring, MD			
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE		22. NAME AND ADDRESS OF FACILITY								\neg
	▶) V	11 0			F	ranci	is Gasch	's Son	is Fur	nera1	Home P.A.	
	1-1emy 2	ton			47	739 I	Baltimore	e Ave.	Hvat	tsvi	111e, MD 20781	
	23. PART i. Enter the diseases, or o shock, or heart fallura.	omplications that	caused the	death. Do	not enter	r the mo	de of dying, auc	h aa cerdii	c or reapi	ratory an		
- 1	IMMEDIATE CAUSE (Final			337							Interval Betwo	
	disesse or condition resulting in death)	ACQU	IR EC	/m	MUNU	EV	EF- ICIE	WCY	SYM	DRI	DME	
İ	resulting in dealthy		SEQUENCE						171.0	7. 2		
,	· ·											
0	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A CON	ISEOUENCE	OF):							-
Ž	cause. Enter UNDERLYING										j	
CERTIFICATION	CAUSE (Disease or Injury that Initiated events	DUE TO (OR AS A CON	SEQUENCE	CE OF):							
FI	resulting in death) LAST										ì	- 1
핑												
_	PART II. Other significant condition	contributing to	death but n	ot resulting	In the u	nderlying	ceuse given in	Part I. 2	4a. WAS AN	AUTOPSY	246. WERE AUTOPSY FINDIN	NGS
3									PERFOR		AVAILABLE PRIOR TO COMPLETION OF CAUS	ar .
EDICA								'	YES 2	NO NO	OF DEATH?	_
Σ	DID TODA CCO LICE COLUT	UD1177 70 011									1 TYES 2 KNO	
Z	DID TOBACCO USE CONTR	IBUIE TO CAL					UNCERTAIN	1				
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN DESCRIPTION OF CHARGE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO OTHER: 1 Inpettert 2 EN/Outpettent 3 DOA 4 Nursing Home 5 Residence 8 Other (Specify) 27. MANNER OF DEATH 28. DATE OF INJURY AT WORK?											\neg	
Z	1 TYES 2 NO	1 Inpetient 2	ER/Outpatien	t 3 🗆 DOA			5 X Residence	8 🗆 Other (Specify)			
E	27. MANNER OF DEATH	28a. DATE OF I		28b. TI	ME OF	28c. INJI WO	JRY AT	28d. DESC	RIBE HOW IN	JURY OC	CURED	
B	1 Natural 5 Pending 2 Accident Investigation	,,	,, ,,		М		ES 2 NO					
	3 Suicide S Could not be	26s. PLACE OF	INJURY - A	t home, ferm	, street, tac	tory, office		28f. LOCAT	ION (Street a	nd Number	r or Rural Route Number,	\neg
_	4 Homicide detarmined	bonding, a	tc. (Specify)					City or	Town, State)			
al III										-		-
_	29a. CERTIFIER			, death occur	rred at the t	time, data	and place, and dua	to the cause	(a) and man	ner as stal	ted.	- 1
AP	29a. CERTIFIER (Check only one)	CIAN: To the best of r	ny knowledge									
OMPL	(Check only	CIAN: To the best of s	my knowledge	/or investigat	lon, in my	opinion, de	eath occured at the	time, date a	nd place, and	d dua to th	ne ceuse(s) and menner as stated	d.
иШ	(Check only	CIAN: To the best of s	my knowledge	Vor Investigat	lon, in my o	opinion, d	eath occured at the 29c. LICENSE NUN		nd place, and		te couse(s) and menner as stated E SIGNED (Month, Day, Year)	d.
# E	(Check only one) 2 MEDICAL EXAMINE	CIAN: To the best of axi	mination and	yeu			29c. LICENSE NUN		nd place, and	29d. DAT	E SIGNED (Month, Day, Year)	
# E	(Check only 2 MEDICAL EXAMINE) 29b. SIGNATURE AND TITLE OF CERTIFIER	tunly	Lu Lu	yen	n				nd place, and	29d. DAT		
IO BE COMPLETE	(Check only 2 MEDICAL EXAMINE) 29b. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUS	E OF DEATH (YEU ITEM 27) (Typ.	oo, Print)		29c. LICENSE NUN D26354	IBER		29d. DAT	e signed (Month, Day, Year)	
# I	(Check only 2 MEDICAL EXAMINE) 29b. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WHO Dr. Stanley L. Lu	completed causing erner 47	E OF DEATH (yeu	oo, Print)		29c. LICENSE NUN D26354	IBER		29d. DAT	e signed (Month, Day, Year)	
# I	(Check only 2 MEDICAL EXAMINE) 29b. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WHO	completed causing erner 47	E OF DEATH (yeu	oo, Print)		29c. LICENSE NUN D26354	IBER		29d. DAT	e signed (Month, Day, Year)	

ČL, with the state of FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

		TIEGIOTTE			0	-11111	ICAIL	. 01	DEAT	111	HEG. NO.			
		1. DECEDENT'S NAME (First	, Middle, Last)								2. DATE OF DEATH MONTH DA	W V	EAR 3.	TIME OF DEATH
	1	RUSSELL	Н.		BUR	LING	HAM				OCTOBER 19			8.54 A. M
		4. SOCIAL SECURITY NUME	BER	5. SEX	6. AGE (In yrs. la	st birthday)	IF UNDER		IF UNDER		7. DATE OF BIRTH (Month, Day, Year)	8.	BIRTHPL	ACE (State or Foreign Fall
- D		096-12-4525		1 📉 M 2 🗌 F	73	YRS.	MONTHS	DAYS	HOURS	MIN.	October 5,	1922 N	Jew 3	Jeibui raii
2, 3 should		Se. FACILITY NAME (If not in	stitution, give s	treet and number)			9b. CITY,	TOWN C	OR LOCATIO			9c. COUNTY		
60	8	St Mary's H	ospita	1			Leor	nard	ltown			St Ma	arv's	County
- -	DIRECTOR	RESIDENCE OF DEC												
Socie	2	10a. STATE	106. COUNTY				TY, TOWN O						10	Dd. INSIDE CITY
permit. Pages		Maryland	St. M	ary's Co	unty	Gr	eat M	1i11	.S				1	YES 2 NO
Ded.	\¥E	10e. STREET AND NUMBER						101	. ZIP CODE			10g. CITIZE	N OF WH	tates
020 physician. burial-transit	FUNER	447 Church	Drive	Apartme	nt #202				2063	34		of An		
Sicia ial-tr	S I	11. MARITAL STATUS			T EVER IN U.S. AI									American Indian, Vhita, etc.
0020 ng physic he burial	BY	1 Never Married 2 X 3 Widowed 4 Divo	mad	IF YES, GIVE	YXYES 2		1 TES 2 K NO Specify:						Specify:	viina, atc.
C P S					Korea (l		3.7						Whi	Lte
121 afte use a	TEO		EDENT'S EDU		(6	Bive kind of	Work done d	CUPATIO	ON ost of working	g	16b. KIND OF BUS	BINESS/INDUS	TRY	
tal or to to	LET	Elementary/Secondary (0	1-12)	College (1-4 or 5	+)	Do NOT u				1		7.0		
AND 2121 the hospital or attr detached for use once.	COMPL					JIVII	Serv	/1ce					of th	ne Army
LAN the hor detach	8	17. FATHER'S NAME (First, M									NE (First, Middle, Malden	Surname)		
RYL ed by a wid be at	삚	Charles H.		gnam							. Bristol			
MARYLAND 21. retained by the hospital or 5 should be detached for u notified at once.	2	19a. INFORMANT'S NAME (1		1 7 11							oute Number, City or Town			20101
	-	Clara C. We		k Burlin						#202	2, Great M		_	
BALTIMORE, after death. Page 6 may be noval. noval. cell examiner must be 1	П	20a. METHOD OF DISPOSIT	n 3 🗆 Rem	oval from State	20b.PLACE cemetery, cre	AND DATE	OF DISPOSITION (NEW PROPERTY P	TION (Na	ime of	1	10720 I	CATION - CIT		
MO direct		4 Donation 6 Other			_ cemetery, cre Metro	poli				у	1995 Alex	andria	1, Vi	lrginia
ALTIN death. Pag tuneral dir i.	1 1	21. SIGNATIVE OF FUNERA	C SERVICE LIC	V.	M00690				Fam:		of Funeral	Homes	2 & (rematory
BALTIMOR ter death. Page 6 m. the funeral director, wal.	8	Nous	love	Klai	DEM						Terre Hau			
B. d in by the or removal		23. PART i. Enter the di	iseases, or o	omplicetions the	nt caused the de	eath. Do	not enter	the mo	de of dyle	ng, auch	as cardiec or respi	ratory arrea	t,	Approximata
- Po E		ahock, or he iMMEDIATE CAUSE (Fin	eert feliure.	List only one car	use on each line	ð.	~	_0		1	1	-		Interval Batween Onset and Death
within within the cremation, rent, the		diseese or condition	<u> </u>	AUT	Ma	wr.e.	· Le	\bowtie	1	las	do			/
ted with completely ial, cremati		resulting in death)		DUE TO	(OR AS A COMSE	QUENCE O	E)		-	7		2		rous
P.O. BOX 68760. In certificate be executed within	z				U				0					1
X 6 see and an an an an an an an an an an an an an	CATION	Sequentially list conditi if any, isading to imme-		DUE TO	(OR AS A CONSE	QUENCE O	F):							
BOX ate be of prior to prior to	8	cause. Enter UNDERLYi CAUSE (Disease or Inju		n e										<u> </u>
O. I	RTIFIC	that initiated events		DUE TO	(OR AS A CONSE	OUENCE O	NF):							
	E	resulting in death) LAS		d,										
0 0 0 5	0	PART II. Other significa	nt condition	a contributing to	deeth but not	maudiffic	des the cond	Serlvino	s course o	ium in D	Part I. 24a, WAS AN	ALCTORON	T 446 W	TOT AUTODOL PHIOLOGIC
- 20 m	DICAL	(1.7			100	- Cileaderill	- OF	C	event in r	PERFOR		AM	ERE AUTOPSY FINDINGS WILABLE PRIOR TO
Signed Health a		Chart	There	Jais	can y	1 0	110	47	July	gu	1 🗆 YES 2	MO	DF	OMPLETION OF CAUSE F DEATH?
2 de le 2	Σ	DID TODA CCO II	J	-		- 6						V	11	□ YES 2 NO
law has be bept.	SICIAN:	DID TOBACCO U		GIROLE 10 CV					UNC	ERTAIN				
PHYSICIAN: The law this certificate has I with the State Dept rived, or item 23	Ö	25. WAS CASE REFERRED TO EXAMINER?	O MEDICAL	HOSPITAL:			TH (Check o							
ICIAN Sertific the S	1 > 1	1 TYES 2 TONO		/1	ER/Outpatient 3		4 🗆 Nursi	Ing Hom		-	Other (Specify)			
O # ## 5	H	27. MANNER OF DEATH	Pending	28a. DATE OF (Month, E		26b. TIN	NE OF I		RK?		28d. DESCRIBE HOW II	NJURY OCCUP	RED	
ON OP DING PHYSIS CARE this call with s marked,	BY	2 Accident	Investigation				М		YES 2	NO				
ATTENDING ECTOR: After s after death	<u>a</u>		Could not be	28a, PLACE C building,	OF INJURY — At he atc. (Specify)	ome, farm,	street, facto	ery, office	•		28f. LOCATION (Street a City or Town, State)	nd Number or	Rural Rout	e Number,
DIVISION OR ATTENDING P DIRECTOR: After thours after death New 28 is mark	E		untar trining .											
	립										o the cause(s) and man			
HOSPITAL FUNERAL Within 72	COMPLET	one) 2 MEDI	CAL EXAMEN	Con the ballis of a	xamination and/or	Investigation	on, in my op	olnion, d	eath occure	ed at the ti	ime, data and placa, an	d due to the c	ause(a) ar	nd manner as stated.
E HO	BE C	295. SIGNATURE AND TITLE	OF CENTIFIER	1					29c. LICE	NSE NUME	BER	294. DATE S	ICHED IM	inth, Ow, Har)
TO THE HOSPIT TO THE FUNERA De filed within 7	0 8		1	7					110	991	7	D 10	/19	195
	F4	The National Control of the Control		COMPLETED CAU	SE OF DEATH (ITE	M 27) (Type	, Print)				/	7	4	
10)			OYD M.J	2			LEONA	RDT	OWN . M	1D. 2	0650	/		i
		OCT 2	Year)	28 ANGISTA	R'S SIGNATUR	J. H			,					
		0012	3 1995	Juna	Manday . Mal									



		FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPARTI				GIENE				
		1. DECEDENT'S NAME (First, Middle, Last) Melvin	James	Bufle	1		2. DATE OF DE		S. TIME OF DEATH			
1/7		4. SOCIAL SECURITY NUMBER 579-50-0524 98. FACILITY NAME (If not institution, give at	1 M 2 F	57 YRS.	F UNDER 1 YEAR ONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.		3 1938	BIRTHPLACE (Stere or Foreign Country) Washington DC			
1, 2, 3 should	TOR	Prince Georges Co				ly, Mary		9c. COUNTY	e George's			
permit. Pages 1,	DIRECTOR	N/A 10b. COUNTY	N/A		town on Locat				10d. INSIDE CITY LIMITS? 1 YES 2 ND			
. Jisi	VERAL	5119 Astor Place	S.E. #202		101.	20019			ed States			
ng physician.	BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Divorced	12. WAS DECEDENT EVER II FDRCES? 1 1 YES IF YES, GIVE WAR OR D.	2 TND	If yea, apo	ENDENT OF HISPAN polity Cuban, Mexican 2 NO Specify	n, Puerto Rican,	ecify Yes or No- 14	RACE — American Indian, Black, White, etc. Specify: Black			
A 1 A 1 3 - 0 al or attending for use as the	ETED	15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12)	CATION	16a. DECEDENT'S US	SUAL OCCUPATION done during mos	N st of working	16b. KIND	OF BUSINESS/INDUS				
the hospit detached once.	COMPL	12 17. FATHER'S NAME (First, Middle, Last)	0	Dietary	Specia	11ist 18. MOTHER'S NAI		A Hosptia Maiden Surname)	1			
retained by 5 should be notified at	TO BE	William Dorsey E					loute Number, Ch	ty or Town, State, Zip Co				
ay be page		Lillie M. Butler 20a. METHOD OF DISPOSITION 1x Burial 2 Oremetion 3 Reme	200	o. PLACE AND DATE OF netery, cramatory or othe	DISPOSITION (Na or place)	ma of	02 Was	hington. 20c. LOCATION — CITY				
death. Page 6 m threat director, i.		4 Donatine of Soveral Service Lice	ENSEE	Harmony M	22. NAME AN	D ADDRESS OF FAC		Landov uneral Hon	mes MD.			
wh. 24 hours after apletely filled in by the cremation, or remova		23. PART I. Enter the diseases, of c shock, or heert felture. I IMMEDIATE CAUSE (Finel disease or condition resulting in death)	Musice Co	each line.	t enter the mo	de of dyling, such	n ee cerdiec d	or reaplicatory erree	t, Approximate Interval Between Onset and Death			
th certificate be executed by physician and il Hygiene prior to bur or other traumatifications.	ERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated eventa resulting in death) LAST b. Due to (or as a conseduence of): Due to (or as a conseduence of): d.										
ires that the d signed by the Health and Mei	EDICAL C	PART II. Other algnificent condition	s contributing to death b	out not resulting in	the underlying	g ceuse given in		WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 ND			
has b Dept.	M:WA	DID TOBACCO USE CONTI 25. WAS CASE REFERRED TO MEDICAL	RIBUTE TO CAUSE O	OF DEATH YES		UNCERTAIN	VB		1 TES 2 NO			
CLAN: ertifica the Str	PHYSICI	EXAMINED 1 DES 2 NO 27. MANNER OF DEATH	HOSPITAL: 1 Inpetient 2 ER/Out		OF 28c, INJ	e 5 Residenca URY AT		cify) E HOW INJURY OCCUP	RED			
ATTENDING PHYSICTOR: After this of after death with 28 Is marked,	D BY	1 Netural 5 Pending 2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJURN building, etc. (Spe	r — At home, term, etc.	M 1 🗆 1	res 2 ND	28f. LOCATION City or Tow	(Street and Number or vn, State)	Rural Route Number,			
PIPE DIRE	COMPLETE	29a. CERTIFIER 1 CERTIFYING PHYSI	CIAN: To the best of my know									
THE HOSPITAL TO THE FUNERAL OF filed within 72 IMPORTANT: If I	BE CO	29b. SIGNATURE AND TITLE OF CERTIFIED	Dechus	on and/or investigation,	In my opinion, d	LICENSE NUN	-		COMED (Marris, Day, Marr)			
2 2 3 3	5	36 MAMIL AND ADDRESS OF PERSON WH	O COMPLETED CAUSE OF DE	TATH (ITEM 27) (Type, P	e Par	hound	10.	Sou Vi	1 20 7 1			
8)		IL DATE PILED OCT 23 1995	Jahra David	ATTHE Randell	1 rug	prwery C	19	Jo .Jh	10/48			

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. BALTIMORE, MARYLAND 21215-0020 IMPORTANT. If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

FOR

STATE OF	MARYLAND / DEPARTMENT	OF HEALTH AND	MENTAL HYGIEN
	CERTIFICATE	OF DEATH	REG. NO.

REGISTRAR			CE	RTIF	CATE O	F DEATH		REG. NO).		
1. DECEDENT'S NAME (First,	Middle, Last)		·				2. DATE	OF DEATH	MY	VEAD	3. TIME OF DEATH
Ida Vermell	Le But1	ler					Octu	ha 11	199	YEAR	12 00
SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In yrs. last b		IF UNDER 1 YEA		7. DATE	OF BIRTH			PLACE (State or Foreig
578-09-4418	8	1 M 2 F	83	YRS.	MONTHS DAY	8 HOURS MIN.	Sept	9 19	12		ter, SC
a. FACILITY NAME (If not ins		set and number)			9b. CITY, TOW	N OR LOCATION OF D	EATH		Sc. COUN	ITY OF D	EATH
2100 Porto					Suit1	and, Mary	land		Prin	ce G	eorge's
De. STATE	10b. COUNTY		2		, TOWN OR LO	1000					10d. INSIDE CITY LIMITS?
Maryland	Prince	e George	's	Sui	tland,	Maryland			_		1 X YES 2 NO
e. STREET AND NUMBER						10f. ZIP CODE					VHAT COUNTRY?
2100 Porter						20746					States
. MARITAL STATUS Never Married 2 1 Widowed 4 Divor	Married	12. WAS DECEDEN FORCES? 1 IF YES, GIVE W	T EVER IN U.S. ARMI	ED	If yes	DECENDENT OF HISPA specify Cuban, Maxic YES 2 NO Speci	an, Puerto		s or No—	14. RACE Black Speci	- American Indian, c, Whita, atc.
15. DECE	DENT'S EDUCA	ATION	16a. DECE	EDENT'S	USUAL OCCUP	ATION	16b	KIND OF BU	ISINESS/IND	USTRY	
Elementary/Secondary (0-	highest grade ci	College (1-4 or 5	life D	o NOT use	e retired.)	most of working					
12		0	Li	ibra	rian			Educa	tion		
FATHER'S NAME (First, Mic	ddle, Last)					16. MOTHER'S N.	AME (First,	Middle, Malder	Sumame)	4000	
George Por	rter					Annie	McDu	iffie			
. INFORMANT'S NAME (7)			19b.	MAILING	ADDRESS (Stre	et and Number or Rural	Route Num	ber, City or Tox	wn, State, Zip	Code)	
Warren Bu	t1er			2100	Porte	r Ave Sui	tland	l, Mar	yland	207	46
a. METHOD OF DISPOSITION	ON	- CONTRACTOR	20b. PLACEAN	ID DATE O	F DISPOSITION		DAT		OCATION -		
☐ Burlal 2/2 Cremetton		val from State	Linco	etory or ot	Memori	a1	10	/20	Suit	1and	, MD
. SIGHATURE OF PURENAL	SENTOF LICE	free	10		22. NAMI	AND ADDRESS OF F	ACILITY				
# 1 1/1V	1	1,001	1X			exander S					
new	1.1	appe	11			38 Marlbo					. MD 2074
3. PART I. Enter the dis	seasea, or co	ing feations the	t caused the dest	th. Do n	ot enter the	mode of dying, eu	ch aa can	diac or reap	piratory arr	wat,	Approximate interval Bety
MMEDIATE CAUSE (Fin		not only only	on duon mio.								Onset and D
isease or condition	+ .	Alz	heimer Di	isea	se						8 year
		DUE TO	(OR AS A CONSEQU	JENCE OF	F):						
	. C b.		dder (Cai								2 year
sequantially list condition in the condi	diate	DUE TO	(OR AS A CONSEQU	JENCE OF	F):						
ause. Enter UNDERLYII AUSE (Disease or inju											
hat initiated events		DUE TO	(OR AS A CONSEOU	JENCE OF	7:						
eaulting in death) LAST	6.										
ART il. Other algolficar	nt conditions	contributing to	death but not re-	suitina l	n the under	ving cause given is	n Part i	24a, WAS A	N AUTOPSV	2.4h	. WERE AUTOPSY FIND
						, g · · · · · · · · · · · · · · · · ·		PERFO	RMED	1	AVAILABLE PRIOR TO COMPLETION OF CAU
								1 TYES	2 NO		OF DEATH?
						1					1 TYES 2 NO
DID TOBACCO US		IBUTE TO CA			S NO	UNCERTA	IN L	L			
S. WAS CASE REFERRED TO EXAMINER?	-	HOSPITAL:	26. PLACE	OF DEAT	OTHER:	ohe)				-	
1 TYES TO NO			☐ ER/Outpetient 3 □	DOA		Home K Residence	6 🗆 Othe	er (Specify)			
MANNER OF DEATH		28a. DATE Of (Month, L	F INJURY Day, Year)	28b. TIM	E OF 28c.	INJURY AT WORK?	28d. DE	SCRIBE HOW	INJURY OC	CURED	
	Pending Investigation	N	/A	N/	A M 1	YES 2 NO					
3 Suicide 8	Could not be	28a. PLACE (OF INJURY At hom, atc. (Specify)	ie, farm, s	street, factory,	office	28f. LOC	or Town, State	t and Number	or Runti	Route Number,
4 Homicide	determined										
Check only	IFYING PHYSIC	JAN: To the best o	f my knowledge, dast	th occurre	ed at the time,	data and place, and du	an lo the ca	use(a) and m	anner aa sta	ted.	
CONTROL ONLY						on, death occured at th					a) and manner as stat
b. SIGNATURE AND TITLE			~ 10						,		
SIGNATURA AND TITLE	N CHILIPPEN	CAN 9	+). Nh	MI		DO 3	396		29d, UAT	ot la	(Month, Day, Year)
lvam	PEROCH IN	100	J N/1		0.1-0					Clobbo	17,1993
Robert	Try ba	Dibh	ne my	116	60 VAV	num St 1	12	Was	hosto	- 0,	0 20017
		32 AEGISTR	PAS SIGNATURA	dall							
Robert .	Tryba	Dibh	ne my	116	60 VAV	num St /	V E	WOI	heyto	- 0,	0 20017

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BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within-T4 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit mermit pages 1, 2 should
be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burfal, cremation, or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CERTIFIC	ATE OF D	EATH	REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)	Blake			1	DATE OF DEATH MONTH DA	YEAR	3. TIME OF DEATH	
		5. SEX 6. AGE (1)			UNDER 24 HRS. 7	P. DATE OF BIRTH (Morith, Day, Year)		HPLACE (State or Foreign fry)	
O.B.	9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH								
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY								
	MD Prince	Prince George's Upper Marlboro 1 Ves 2 M AND NUMBER 101. ZIP CODE 109. CITIZEN OF WHAT COUNTRY?							
FUNERAL	45 Oueen Ann Bri	dge Road		4 5 5 5 5	20772		U.S.		
B≼	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 ☐ YES IF YES, GIVE WAR OR DA	2 X NO	If yes, specify	ENT OF HISPANIC Cuben, Mexican, NO Specify:	ORIGIN? (Specify Yes Puerto Rican, etc.)	or No- 14. RAC Black Spec	E — American Indian, ik, White, stc. city: Black	
COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade or Elementary/Secondary (0-12)	TION ompleted) College (1-4 or 5+)	16s. DECEDENT'S USI (Give kind of work life, Do NOT use re	UAL OCCUPATION done during most of tired.)	working	16b. KINO OF BUS	SINESS/INOUSTRY		
OMP	1st 17. FATHER'S NAME (First, Middle, Last)		Saw Mil	l Worker		Priva			
BE C	Richard E. Blake				Ethel Jo	(First, Middle, Maiden	Sumsme)		
10 E	19s. INFORMANT'S NAME (Type/Print)			DRESS (Street and h	iumber or Rural Rou	te Number, City or Town			
	Charles S. Blake 20a METHOD OF DISPOSITION 1 Burlel 2 Cremetion 3 Remove		PLACE AND DATE OF D	ISPOSITION (Name of		DATE 20c. LOC	CATION - City or T	own, State	
	4 Donation 6 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICER		ones Cemet	22. NAME AND A	DDRESS OF FACIL	IIY		ville,MD	
	>\ Mauran	10	Blackm			Funeral		MD 20785	
	23. PART i. Enter the diseases, or con ahock, or heart failure. Li IMMEDIATE CAUSE (Final disease or condition	at only one ceuse on as	och ilne.	enter the mode	of dying, such a	a cardiac or reapir	ratory erreat,	Approximata Interval Between Onset and Death	
	resulting in desth) a.		CONSEQUENCE OF):					Pays	
ATION	Sequentially list conditions, if any, leading to immediate cause. Entar UNDERLYING								
CERTIFICATION	CAUSE (Disease or injury that Initiated events resulting in death) LAST d								
1 1	PART II. Other significent conditions contributing to deeth but not resulting in the underlying ceuse given in Part i. 24e. WAS AN AUTOPSY PERFORMED? AMALABLE PRIOR TO								
MEDICAL	1 U YES 2 NO COMPLETION OF CAUSE OF DEATH?								
N. W	DID TOBACCO USE CONTRI				JNCERTAIN			1 YES 2 NO	
SICIA		OSPITAL:		THER:	- PERSON DA				
PHYSICIAN	27. MANNER OF DEATH 1 Natural 5 Pending	26s. DATE OF INJURY (Month, Day, Year)	28b. TIME OF	WORK?		J Other (Specify) Bd. DESCRIBE HOW IN	JURY OCCURED		
red BY	2 Accident Investigation 3 Suicide 8 Could not be determined	26s. PLACE OF INJURY building, etc. (Speci	— At home, ferm, stree fy)			81. LOCATION (Street as City or Town, State)	nd Number or Rural	Route Number,	
COMPLET		AN: To the best of my knowle						s) and manner as stated.	
BE	29b. SIGNATURE AND TITLE OF CERTIFIER	.M ns		296	LICENSE NUMBE	R	29d. DATE SIGNED	(Month, Day, Year)	
5	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF OEA	TH (ITEM 27) (Typo, Print Laure Be	owie Rd	#307 L	awel M	D 2070	per 21,1995	
	31. DATE FILED (Month, Day, Year) / OCT 241995	32. HEGISTRAP'S SIGNA	TURED AND AND AND AND AND AND AND AND AND AN						

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n. ansit permit. Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-trace filled within 72 hours after death with the State Deft. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

							9	5 33910		
	1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPAR CERTIF	RTMENT OF	HEALTH AND I	MENTAL HYGIEN REG. NO				
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF OEATH MONTH D	AY Y	3. TIME OF DEATH		
	4. SOCIAL SECURITY NUMBER	MICHAFI 5. SEX 6. AGE	BARBER (In yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	OCTOBER 1	7, 199	5 1:33 PM BIRTHPLACE (State or Foreign		
		Land of the seco	M 2 F 33 YRS. MONTHS DAYS HOURS MIN. A		Aug 22,1962 Was		country asnington D.C.			
	9e. FACILITY NAME (If not institution, give stre	eet and number)		9b. CITY, TOWN	OR LOCATION OF DE		9c. COUNTY			
OR	Prince George's Hospital Center			Ch		e George's				
DIRECTOR	10a. STATE 10b. COUNTY		-	Y, TOWN OR LOC	ATION			10d. INSIDE CITY		
DIA	MD Prince	George's	La	ndover				LIMITS? 1 ☐ YES 2 ☑ NO		
FUNERAL	10e. STREET AND NUMBER			1	Of. ZIP CODE		OF WHAT COUNTRY?			
NE	1822 Palmer Park	Road 12. WAS DECEDENT EVER I			20785			J.S.A.		
	1 Never Married 2 K Married	FORCES? 1 YES	2 PNO	Il yes, s	ECENDENT OF HISPAN specify Cuben, Mexica S 2 1 NO Specify		a or No- 14	RACE — American Indian, Black, White, atc. Specify:		
ВУ	3 Widowed 4 Divorced			'''		,. 		Black		
TE	15. DECEDENT'S EDUCA (Specify only highest grade of	ompleted)	18e. DECEDENT'S (Give kind of life, Do NOT u	Work done during in secretized 1	TION nost of working	18b. KIND OF BU	SINESS/INDUS	TRY		
P	Elementary/Secondary (0-12)	College (1-4 or 5 +)	Landso	,		ים	rivate			
COMPLETED	17. FATHER'S NAME (First, Middle, Last)		Domase	400	18. MOTHER'S NA	ME (First, Middle, Maiden				
BE (Joseph Barber					Christian				
2	190. INFORMANT'S NAME (Type/Print)					Route Number, City or Tov				
	Robin Barber 20a, METHOD OF DISPOSITION 1 & Burlel 2 Cremetion 3 Remov	201	b. PLACE AND DATE			Landover		O Town, State		
	4 Donetton 5 Other (Specify)	A H	armony N	lemorial	Park	1995 L	andove	, MD		
	21. SIGNATURE OF FUNERAL SERVICE LICE	NSEE A								
	Julian	d ()-10	rucken					er,MD 20785		
	23. PART I. Enter the diseases, or co shock, or heart failure. Li	implications that cause lat only one cause on a	d the death. Do ech line.	not enter the m	ode of dying, suc	h sa cardiac or reap	iratory arrest	Interval Batween		
	IMMEDIATE CAUSE (Final disease or condition resulting in death)	MADICED C	ADDIAG	VEEDTE	DI IV AND D	XI ATATZONI		Onset and Death		
	resulting in death) . a.	death) a. MARKED CARDIAC HYPERTROPHY AND DILATATION DUE TO (OR AS A CONSEQUENCE OF):								
NO N	Sequentially list conditions, CALCIFIED AORTIC AND MITRAL VALVES DUE TO (OR AS A CONSEQUENCE OF):									
CAT	11 any, leading to Immediate cause. Enter UNDERLYING CONGESTION AND EDEMA OF LINGS									
ERTIFICATION	CAUSE (Disease or injury that initiated events	et initiated events OUE TO (OR AS A CONSEQUENCE OF):					1.00			
CER	d. END STAGE RENAL FAILURE									
4	PART II. Other significant conditions	contributing to death it	but not resulting	In the underlyi	ng ceuse given in	Part I. 24a. WAS AP		24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO		
MEDICA						1 YES	2 NO	OF DEATH?		
Σ.	DID TOBACCO USE CONTRI	BUTE TO CAUSE O	DE DEATH Y	FS NO	UNCERTAIN	u N		YES 2 NO		
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL		28. PLACE OF DEA			- 14				
YSIC	1 TYES 2 NO	HOSPITAL: 1 Inpetient 2 ER/Out	patient 3 DOA	OTHER:	me 5 - Residence	8 Other (Specify)				
	27. MANNER OF DEATH 1 Natural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b. TIN	JURY Y	YURY AT YORK?	28d. DESCRIBE NOW	INJURY OCCUP	RED		
ВУ	2 Accident Investigation 3 Suicide 8 Could not be	28e. PLACE OF INJURY	Y — At home, larm,			281. LOCATION (Street	and Number or	Rural Route Number,		
	4 Homicide determined	building, etc. (Spe	icify)			City or Town, State)			
COMPLETED		IAN: To the best of my know	viadga, death occur	red at the time, da	te and place, and due	to the cause(a) and ma	nner as stated.	-50		
SON	one) 2 MEDICAL EXAMINER	basis of examinetic	on and/or investigati	on, in my opinion,	death occured at the	time, date and place, e	nd dua to the c	ause(a) and manner as stated.		
BE	296. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUN	WBER	29d. DATE S	IGNED (Month, Deg. Year)		
2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DE	EATH (ITEM 27) (Type	a, Print)	1170	57/		1 20/9)		
		4 Queensb	ury Roa		rdale,M	aryland	20737			
	31. DATE FILED (Month, Day, Year) OCT 241995	32 ARCHETRIB'S SIGN	ATURACE.							
		IV.								

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HOSPITAL

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31. DATE FILED (Month, Day, Year)
OCT 25 1995

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. OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed wit. 24 hours after death. Page 6 mi	DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,		Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must
s after	by the	emoval	dical
Мощ	Pi Pi	0	E
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 -CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH OCTOBER 20 1995 2400 P DOROTHY BOWENS 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year) 5. SEX 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. BIRTHPLACE (State or Foreign
Country) DAYS MONTHS 1 M 2 T F 77 227-14-4718 Mar 18 1918 Fauquier, VA 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR HARFORD MEMORIAL HOSPITAL HARFORD RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Prince Georges Temple Hills, Maryland TY YES 2 NO 10e. STREET AND NUMBER FUNERAL 101, ZIP CODE 10a. CITIZEN OF WHAT COUNTRY? 1914 Colebrooke Drive 20748 United States 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENOENT OF HISPANIC ORIGIN? (Specify Yas or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. RACE - American Indian, Black, White, atc. FORCES? 1 YES 2 1 Never Merried 2 K Married 1 YES 2 TO Specify: Specify BY 3 Widowed 4 Divorced **Black** 16a. DECEDENT'S USUAL OCCUPATION ETED 15. DECEDENT'S EDUCATION 16h KIND OF BUSINESS/INDUSTRY (Specify only highe (Give kind of work done life, Do NOT use retired.) Elamentary/Secondary (0-12) College (1-4 or 5+) COMPL 12 Nurse P. G. Hospital once. 17. FATNER'S NAME /First Middle Last 18. MOTNER'S NAME (First, Middle, Meiden Surname) 10 **Ernest Jones** Maude Donell BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 George Gibson Jr. 1914 Colebrooke Dr Temple Hills, MD 20748 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State 4 🗆 Donastan Metropolitan Crematory 10/25 Alexandria, VA OF FUNERAL SERVICE LICENSES 22. NAME AND ADDRESS OF FACILITY
Alexander S. Pope Funeral Homes 5538 Marlboro Pike Forestville, Md. 20747 23. PART I. Enter the diseases, or complications that c Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory strest, shock, or heert fellure. List only one ceuse on each line. Interval Batween **IMMEDIATE CAUSE (Final** Onset and Death disesse or condition resulting in deeth) er ioxlent CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF) if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF) that initieted events resulting in deeth) LAST PART II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS 24s. WAS AN AUTOPSY MEDICAL PERFORMED? MAII ARI E PRIOR TO COMPLETION OF CAUSE 1 TYES 2 NO 1 TES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES INO INCERTAIN A PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one, **EXAMINER?** HOSPITAL: OTHER: 1 X YES 2 NO 1 | Inpatiant 2 | XER/Outpatient 3 | DOA 4 Nursing Nome 5 Residence 8 Other (Specify) 27. MANNER OF DEATN 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d, DESCRIBE NOW INJURY OCCURED marked, 1 Natural М 1 YES 2 NO BY N/A Investigation N/A Accident N/A 28e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 3 Suicide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be COMPLETED 4 Homicide N/A 29s. CERTIFIER 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data end place, and due to the cause(s) and manner as attated. FUNERAL I within 72 h 2 MEDICAL EXAMINER: On the basic of exemination end/or investigation, in my opinion, death occured at the time, date end place, and due to the cause(e) end manner as stated **MPORTANT**: 29c. LICENSE NUMBER 29d, DATE SIGNED (Month, Day, Year) BE OCTOBER 21 1995 O.C.M.E. 2 WNO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

DHMH-16 Rev 1/89

Janes Commence

YEAR

9c. COUNTY OF DEATN

Montgomery

U.S.A.

Specify

Ohio

1995

3. TIME OF DEATN

10:10 a

10d, INSIDE CITY

14. RACE — American Indian, Black, White, etc.

White

Approximate

5 hours

2 weeks

24b. WERE AUTOPSY FINDINGS

1 YES 2 NO

October 21, 1995

AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?

2-4 years

Interval Between Onset and Death

NES YES 2 NO

8. BIRTNPLACE (State or Foreign

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH Walter Alfred Brester October 4. SQCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year) 8. AGE (In yrs. last birthday) IF UNDER 24 HRS. 269-09-2422 DAYS HOURS 1 🖳 M 2 🗌 F 84 Oct. 18, permit. Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street end number, 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR Holy Cross Hospital Silver Spring 10c. CITY, TOWN OR LOCATION None None Washington, D.C. 10e. STREET AND NUMBER FUNERAL use as the burial-transit 4825 16th Street N. 20017 retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED 11. MARITAL STATUS BALTIMORE, MARYLAND 21215-0020 FORCES? 1 YES 2 NO 1 Never Merried 2 K Married 1 TYES 2 NO Specify: BY 3 Widowed 4 Divorced ETED. 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION (Specify only high Elementary/Secondary (0-12) College (1-4 or 5+) funeral director, page 5 should be detached for COMPL 5+ Electrical Engineer 17. FATHER'S NAME (First, Middle, Last) Ħ Carl Brester BE notified 19a. INFORMANT'S NAME (Type/Print) 2 Bertha R. Brester pe 20e. METHOD OF DISPOSITION
t 및 Burlel 2 ☐ Cremation 3 ☐ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of must t Burlei 2 Cremation 3 L 4 Donetion 5 Other (Specify) examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY hours after death. 3 n and completely filled in by the to burial, cremation, or removal. medical shock, or heart failure. List only one cause on each line IMMEDIATE CAUSE (Final the disease or condition resulting in death) Congestive Heart Failure / Pulmonary Edema event, DUE TO (OR AS A CONSEQUENCE OF): DIVISION OF VITAL RECORDS, P.O. BOX 68760 executed Acute Myocardial Infarction traumatic CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF): if any, leeding to immediate the attending physician Mental Hygiene prior to Aortic Stenosis cause. Enter UNDERLYING CAUSE (Disease or Injury other 1 DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 PART II. Other algorificent conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL Health and I PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES DI NO DI UNCERTAIN DI has b Dept. OR ATTENDING PHYSICIAN: The law 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) certificate to the State HOSPITAL: t YES 2 NO t ⊠ Inpatient 2 □ ER/Outpatient 3 □ DOA 4 - Nursing Nome 5 - Residence 8 - Other (Specify) 6 27. MANNER OF DEATN 28b. TIME OF 28s. DATE OF INJURY (Month, Day, Year) this c 28c. INJURY AT marked, 1 2 Netural 1 YES 2 NO BY After 2 Accident investigation 28e. PLACE OF INJURY — At home, farm, street, tectory, office building, etc. (Specify) 3 Suicide 28 is COMPLETED 6 Could not be DIRECTOR: / 4 Homicide hours TO THE FUNERAL TO THE FUNERAL DE filed within 72 h HOSPITAL 29b. SIGNATURE AND TITLE OF CUITIFIED 29c. LICENSE NUMBER BE D29293 2 NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

10g. CITIZEN OF WHAT COUNTRY? 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—
If yes, specify Cuben, Mexican, Puerto Rican, etc.) 16b. KIND OF BUSINESS/INDUSTRY W.T.O.P. Radio & Television 18. MOTNER'S NAME (First Middle Maiden Sumame) Clara Houstetter 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 4825 16th Street NE, Washington, D. C. DATE 20c. LOCATION --- City or Town, State Fort Lincoln Cemetery 10/24/1995 Brentwood, Md. 20722 Francis Gasch's Sons Funeral Home - 4739 Baltimore Ave., Hyattsville, Md. 20781 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 24a. WAS AN AUTOPSY PERFORMED? 1 TYES 2 X NO 28d, DESCRIBE NOW INJURY OCCURED 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 29e. CERTIFIER
(Chack only 1 🖾 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(e) end manner as atteted. 2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(e) and menner ee stated. 29d. DATE SIGNED (Month, Day, Year)

A HEGISTAR'S SIGNATURE

Dr. Michael Lincoln, M.D. 10313 Georgia Avenue, Suite 308, Silver Spring, MD 20902

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ING PHYSICIAN: The law requires that the death certificate be executed withins 4 hours after death. Page 6 may be retained by the hospital or attending physician.	this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	as the 22 above any latine, so address desired discuss the entailed averaging manifold at another section of another
IAN: The law re-	tificate has been e State Dept. of	to liber 22 of
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law re-	TO THE FUNERAL DIRECTOR: After this certificate has been be filed within 72 hours after death with the State Dept. of	the Commence of the land of the land of the land of

	FOR 1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPARTM CERTIFICA			MENTAL	HYGIENI REG. NO.	E		
	t. OECEDENT'S NAME (First, Middle, Last)					2. DATE C	F DEATH		2	. TIME OF DEATH
- 1	CHARLES	F	BROWN			MONTH	OBER :		95	3 20A M
	4. SOCIAL SECURITY NUMBER		In yrs. last birthday) IF I	JNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE O	F BIRTH	6.	BIRTHPL	LACE (State or Foreign
R	578-42-2992 9a. FACILITY NAME (If not institution, give etn	1 M 2 F	63 YHS.	CITY TOWAL O	HOURS MIN.	12-0	0ey, Year) 01-19			vland
DIRECTOR	Prince George's									George's
EC	100. STATE 10b. COUNTY		7	WN OR LOCAT	ION				1	lod. INSIDE CITY
E	Maryland Princ	e George's	. Lar	ndover					,	LIMITS?
	10e. STREET AND NUMBER				ZIP CODE			10g. CITIZEN		IAT COUNTRY?
FUNERAL	7232 Landover	Road, Apt	. #D		20785			U.S	. A .	
5	11. MARITAL STATUS	12. WAS DECEDENT EVER IN FORCES? 1 YES	U.S. ARMED		ENDENT OF HISPAN				. RACE -	- American Indian, White, atc.
BY F	t Never Married 2 Merried 3 [X] Widowed 4 Divorced	IF YES, GIVE WAR OR DA			cify Cuben, Maxica 2 pp NO Specify		can, etc.)		Specify:	
								1		DIACK
TE	15. DECEDENT'S EDUC. (Specify only highest grade of	completed)	(Give kind of work in the Do NOT use ret	done during mos	N st of working	16b.	KIND OF BUS	INESS/INDUS	TRY	16-
1	Elementary/Secondary (8-12)	College (1-4 or 5+)	Custo				Priva	ate		
COMPLETED	9th 17. FATHER'S NAME (First, Middle, Lest)		custo	aran	18. MOTHER'S NA	ME (First M				-
				- 4	Annie		apma			
BE	Unknown 190. INFORMANT'S NAME (Type/Print)		19b. MAILING ADD	PRESS (Street a	nd Number or Rural I				ode)	
2	Marguerite Bro	wn/Daughte								MD 20785
	20e. METHOD OF DISPOSITION	20b	PLACE AND DATE OF DE	SPOSITION (Na	me of	OATE	20c. LO	CATION - City	v or Town	n. State
	1 Buriel 2 Cremetion 3 Remo	val from State cem	ermony Me	emoria	1 Park	0/28	Lar	ndove	r.	Marvland
	21. SIGNATURE OF FUNERAL SERVICE LICE	ENSEE		22. NAME AN	D ADDRESS OF FA	CILITY				
	Somberly (Buscre	-10uc		JENKI					20785
	23. PART i. Enter the diseeses, or co	omplications that caused	the death. Do not a		Lando					Approximate
	shock, or heert feilure. L						ac or reap	atory arrow	.,	Interval Batwean Onset and Death
	IMMEDIATE CAUSE (Final disease or condition	Rengin	alone	da.	1.00					mout
	resulting in death)	DUE TO (OR AS A	CONSEQUENCE OF :	Marc	lure					
z		Sei	phini	V						month
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	OUE TO (OR AS	CONSEQUENCE OF):							
CA	CAUSE (Disease or Injury	H1	V dis	eare						years
TIF	that initiated events resulting in desth) LAST	DUE TO (OR AS A	CONSEQUENCE OF):							
ER	readiting in destiny EAST	i								
AL C	PART II. Other significent conditions	contributing to deeth b	out not resulting in th	ne underlying	cause given in	Pert i.	24a. WAS AN			WERE AUTOPSY FINDINGS
							PERFOR	. /		MAILABLE PRIOR TO COMPLETION OF CAUSE
ED						_	1 1 123 2	N.O		OF DEATH?
2	DID TOBACCO USE CONTR	RIBUTE TO CAUSE C	F DEATH YES		UNCERTAIL	NM				
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEATH (1	
SIC	t Tyes 2 XNO	HOSPITAL:	patient 3 DOA 4 D	THER: Nursing Hom	e 5 🗌 Rasidence	8 🗆 Other	(Specify)			
ΉŽ	27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF	28c. INJ	URY AT	28d. OES	CRIBE HOW I	NJURY OCCUP	RED	
ВУБ	1 Natural 5 Pending 2 Accident Investigation	(menun, bus, rous)			ES 2 NO					
	3 Suicide 8 Could not be	28e. PLACE OF INJURY building, atc. (Spec	/ — At home, farm, stree	t, tactory, offic			TION (Street a	and Number or	Rural Ro	ute Number,
1	4 Homicide determined									
COMPLETED		CIAN: To the best of my know	riedge, death occurred at	t the time, data	and place, and due	to the cau	se(e) end mer	ner se stated.		
OM	one) 2 MEDICAL EXAMINE	R: On the besis of examination	n and/or investigation, in	n my opinion, d	eath occured at the	time, date	end place, en	d due to the o	:euse(s)	end manner as stated.
BE C	29b. SIGNATURE AND TITLE OF CERTIFIER	1 SE WAI			29c. LICENSE NUI	MBER		29d. DATE S	IGNED (Month, Day, Year)
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TO	30. NAME AND ADDRESS OF PERSON WHY LIPISHREE	NAYAK	650	1 de	andoi	128	Roa	d, (che	everly
	31. DATE FILEO (Month, Day, Year) OCT 26 1995	32. BEGISTRAR'S SIGN	OF Rarball					,		8

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TO BE COMPLETED BY FUNERAL DIRECTOR	TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION
examiner must be notified at once.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	10 THE FUNEYAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the 1 be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlal, cremation, or removal.
ir death. Page 6 may be retained by the hospital or attending physician.	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within-E4 hours after death. Page 6 may be retained by the hospital or attending physician.

MARK SULKOUSK!

31. DATE FILED (Month, Day, 18er)

OCT 26 1995

1159 POSS 13CO

32/ARGISTRAN'S SIGNATURE

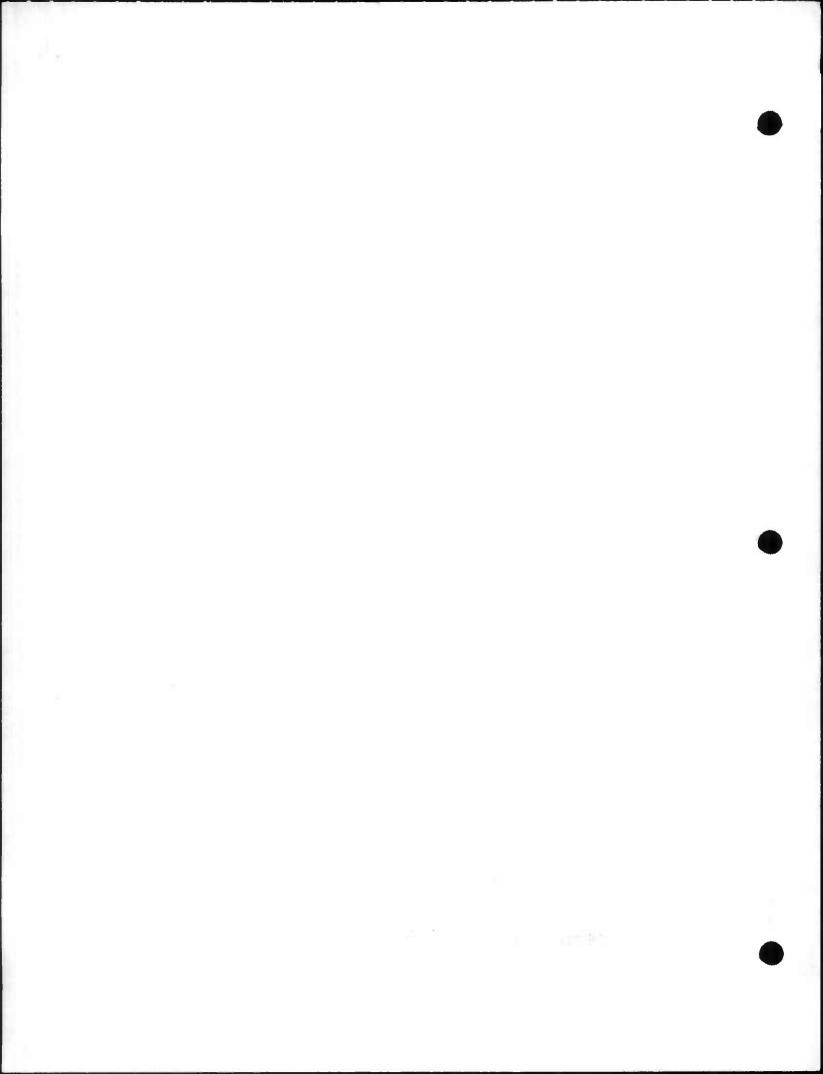
JENNA DRUMBEN RANGEL

							9	95	33914
	1 - FOR STATE OF MARYLAN REGISTRAR	D / DEPAR				MENTAL HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Last) Rush					2. DATE OF DEATH DONTH DOCTOBER	19	YEAR 1995	3. TIME OF DEATH 02:30 AM
FUNERAL DIRECTOR	577-86-1936 1XIH2DF 36	SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, War) (Month, Day, War)						Countr	
	98. FACILITY NAME (If not institution, give street and number) BAYVIEW MEDICAL CENTER RESIDENCE OF DECEMENT		Balti		CATION OF DE	EATN	%c. COUNTY OF DEATN Baltimore		
	10a. STATE 10b. COUNTY MD Prince Georges		r, town or)			10d. INSIDE CITY LIMITS? NO YES 2 NO	
	100. STREET AND NUMBER 112 Dauntly Street			10f. ZIP (7.57			TIZEN OF W	WHAT COUNTRY?
BY	11. MARITAL STATUS 1 Never Married 2 Merried 3 Wildowed 4 Divorced 12. WAS DECEDENT EYER IN U.S FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES	NO	It ye	es, specify (IIC ORIGIN? (Specify Yen, Puerto Rican, etc.)	s or No-	14. RACE Black Speck Bla	
COMPLETED	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	Give kind of the Do NOT u	work done duri se retired.)	ng most of w	rorking	16b. KIND OF BU			hwan b
ш	17. FATNER'S NAME (First, Middle, Last) William B. Bush	rite r	igitei	16. 1		D.C. Fi ME (First, Middle, Melden B. Blackb	Sumame)	epar	tment
TO B	19a. INFORMANT'S NAME (Type/Print) John Ceasar	112 Da	auntly	St.,		Route Number, City or Tow r Marlboro			72
	208. METHOD OF DISPOSITION 14 Burlal 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. SIGNATURE OF PUNERAL SERVICE LICENSEE	ACE AND DATE y, crematory or o	L Ceme	tery	DBESS OF EA	OATE 20c. LO 10/23 Sui	tlan	d, N	
	. P. marshall	2	430	8 Sui	tland	neral Home Rd., Suit	land	, MD	20746
	23. PAPT I. Enter the diseasea, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, ahock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final								
MEDICAL CERTIFICATION	Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. Procressive multirecare Levagence Phatopathy 3 manth DUE TO (OR AS A CONSEQUENCE OF): Cause Consequence of the cause of injury that initiated events resulting in death) LAST								
	PART II. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY PRIDINGS ANALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?								
IAN: N	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 YES 2 NO 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)								
PHYSICIAN:	EXAMINER? 1 YES 2 NO								
TED BY	1 Natural 5 Pending Investigation 2 Accident Suicide 8 Could not ba detarmined 28s. PLACE OF INJURY — building, atc. (Specify)	At home, term,		office	2 NO	28t. LOCATION (Street City or Town, State)	and Numbe	or or Rural A	loute Number,
COMPLETE	29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the bast of examination and) and manner as stated.
TO BE CO	286. SIGNATURE AND TITLE OF CERTIFIER MI)			29c.	LICENSE NUM		29d. DA	TE SIGNED	(Month, Day, Year)
F	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH	(ITEM 27) (Type	, Print)						

BALTIMINE

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Replacement

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page be filed within 72 hours after death with the State Debt, of Health and Mental Hydiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be neitfled at once
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fi be filed within 72 hours after death with the State Debt. of Health and Mental Hydiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other t

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

DIRECTOR

FUNERAL

BY

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COMPL

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CERTIFICATION

PHYSICIAN: MEDICAL

BY

COMPLETED

BE

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30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print)

12 REGISTRAPTS SIGNATURE

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH AUG 00:28 WALTER BELT. 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) APRIL 24 B. BIRTHPLACE (State or Foreign DAYS HOURS 1 XM 2 - F 189-18-2130 YRS. PENNSYLVANIA 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS ANNE ARUNDEL RESIDENCE OF DECEDENT 10c CITY TOWN OR LOCATION 10d. INSIDE CITY MD. ANNE ARUNDEL DAVIDSONVILLE 1 XYES 2 NO 10e. STREET AND NUMBER 10g, CITIZEN OF WHAT COUNTRY? 1524 THEMES DR. 21035 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Merried If yes, specify Cuban, Mexican, Puerto Ri 1 TES 2 NO Specify Specify 3 Widowed 4 Divorced W.W.11 WHITE 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) ELECTRONIC OPTICAL ENGINEER NASA - GSFC 17. FATHER'S NAME (First Middle Lest) 18. MOTHER'S NAME (First, Middle, Meiden Surneme) JOSEPH BELL ALICE SCOTT 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zio Code) S. BRYAN BET.I. THEMES DR. . DAVIDSONVILLE. 20e. METNOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State 1 Burial 2 Cremetion 3 4 Donetion 5 Other (Specify) DATE 3 - Removal from State CREMATORY 8/19 RIVERDALE, 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY 5801 CLEVELAND AVE. M00091 W. W. CHAMBERS CO. RIVERDALE 20737 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Liet only one cause on each line. Approximata Interval Between **IMMEDIATE CAUSE (Final** Onset and Death disease or condition quamous 18ars resulting in death) Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initieted events resulting in death) LAST PART ii. Other algorificent conditions contributing to deeth but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPS 246. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 NO OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO [2] UNCERTAIN [25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) OTHER: 1 TES 2 THO npetient 2 - ER/Outpetient 3 - DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. MANNER OF DEATH 28b. TIME OF INJURY 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d, DESCRIBE NOW INJURY OCCURED 1 Natural 5 Pending 1 YES 2 NO 2 Accident 28e. PLACE OF INJURY — At home, farm, street, fectory, office building, etc. (Specify) 3 Suicide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 4 Nomicide 29s. CERTIFIER t CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(e) end manner es stated. 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner as stated. 296. SIGNATURE AND TITLE OF CENTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)

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DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within an hours	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or ri	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the med
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29b. SIGNATURE AND TITLE OF CERTIFIER

L. AERY

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

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32 TENSTRAU AGLABARE CARCALL

Hubert L Frery

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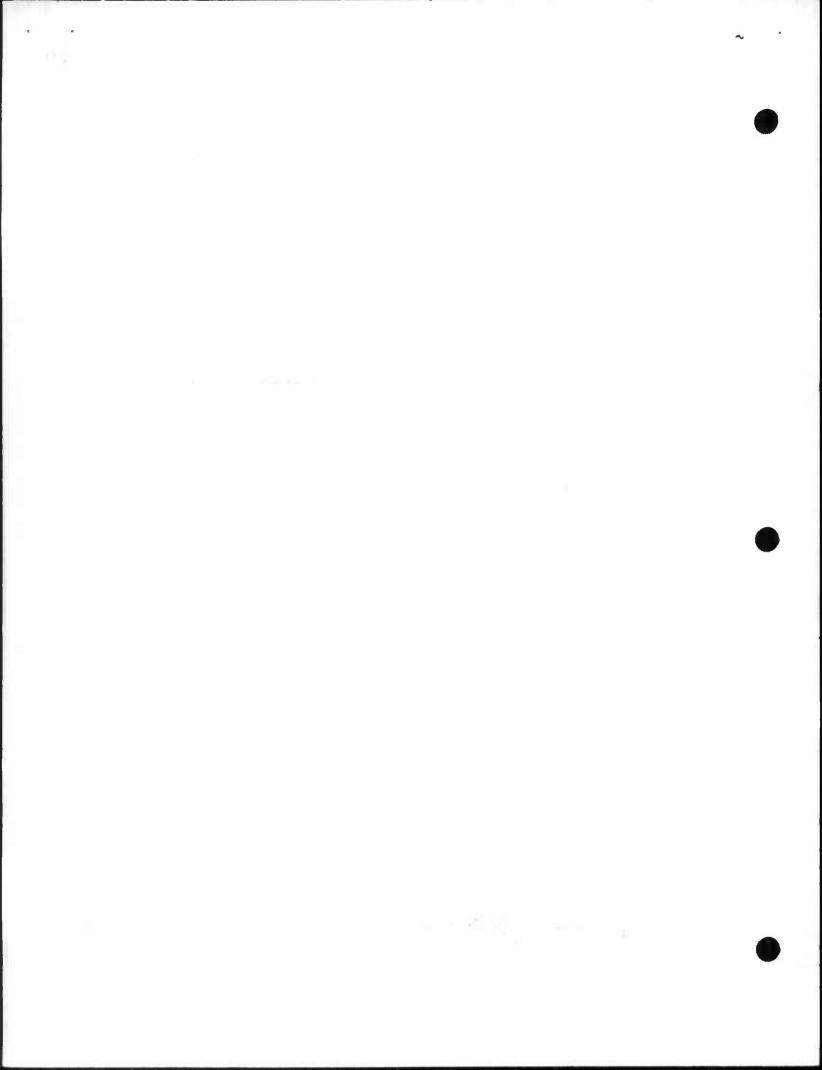
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FOR STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH LUCY CORNISH 10 6. AGE (In yrs. lest birthday) 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Ybar) IF UNDER 1 YEAR IF UNDER 24 HRS. DAYS HOURS 8-16-6452 1 M 2 D YRS. permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR Glasgow Nursing Home Cambridge RESIDENCE OF DECEDENT 10a. STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION Maryland Dorchester Cambridge FUNERAL 10a STREET AND NUMBER 10f. ZIP CODE director, page 5 should be detached for use as the burial-transit 311 Glenburn Avenue 21613 Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or NoIf yes, specify Cuben, Mexicen, Puerto Rican, etc.)
1 YES 2 NO Specify: BALTIMORE, MARYLAND 21215-0020 FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 1 Never Merried 2 Merried BY 3 🔣 Widowed 4 🗌 Divorced 8 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) (Specify only highest grade COMPLET Elementary/Secondary (0-12) College (1-4 or 5+) 8 Domestic Work 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Meiden Surname) 76 George Travers Sarah Travers notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Yown, State, Zip Code) 9 Elizabeth Garrison 414 Camper Street Cambridge, Maryland21613 2 20s. METHOD OF DISPOSITION
11 Burlel 2 Cremetton 3 Removal from State
4 Donation 6 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of OATE must Beckwith Neck Cemetery10/ examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY the funeral after death. Henry Funeral Home 23. PARTY Enter the diseases, or complications that caused the deeth. Do not anter the mode of dying, such as cerdiac or respiratory street, shock, or heart failure. List only one cause on and light street. medicai filled in by ahock, or heart failure. List only one cause on each line. 0 IMMEDIATE CAUSE (Final the cremation, disease or condition resulting in death) the attending physician and completely 'Mental Hygiene prior to burial, crematic CONGESTIVE HEART FAILURE event, DUE TO (OR AS A CONSEQUENCE OF): ARTERIOSCLETOTIC HEART DISENSE traumatic CERTIFICATION Sequentially list conditions, OUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING HYPERTENSILE CARDIOVISCULAR DISENSE certificate CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST death c 6 PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. MEDICAL Health and amy FALLURE ANEMIA Shows certificate has been in the State Dept. of P DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: MP 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) The Hem **EXAMINER?** HOSPITAL: OTHER 4 Linuxing Home 5 Residence 6 Cother (Specify) PHYSICIAN: 1 | YES 2 | NO 1 | Inpetient 2 | ER/Outpetient 3 | DOA 6 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? this c 28b. TIME OF marked, 1 Natural 5 Pending 1 YES 2 NO BY After 2 Accident Investigation ATTENDING 28e. PLACE OF INJURY — At home, ferm, street, fectory, office building, etc. (Specify) 3 Suicide 8 Could not be determined 66 COMPLETED DIRECTOR: / 4 🗌 Homicide 28 tem OH O 29e. CERTIFIER
(Chack note of the course)

1 **Description** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as attend. FUNERAL within 72 H

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 3. TIME OF DEATH 6:15 A-M 25 95 8. BIRTHPLACE (State or Foreign 01-05-190 Maryland 9c. COUNTY OF DEATH Dorchester 10d. INSIDE CITY 1 YES 2 NO 10g. CITIZEN OF WHAT COUNTRY? USA 14. RACE — American Indian, Black, White, etc. Specify: Black 16b. KIND OF BUSINESS/INDUSTRY Private Family 20c. LOCATION - City or Town, State 28 Cambridge, Maryland 510 Washington St.Cambridge, Md. 21613 Approximate Intarval Between Onset and Death HUURS YEM25 1/LARS 24e. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 TYES 2 THO 1 YES 2 NO 28d. OESCRIBE HOW INJURY OCCURED 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 10/25745 022773

CAMBRIDGE MAPYLAND 2161



DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

permit. Pages 1, 2, 3 should

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transbe filled within 72 hours after death with the State Debt, of Heath and Mental Hydiene prior to burial, cremation, or remand.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
TENDING PHYSIC	TOR: After this ce	28 is marked,
TO THE HOSPITAL OR AT	TO THE FUNERAL DIRECT De filed within 72 hours a	IMPORTANT: If Item 2

PHYSICIAN:

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31. DATE FILED (Month, Day, Year)

OCT 3 1

30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

1995

M.D. 3710

32. REGISTRAR'S SIGNATURE
JULY DRUGIST RONDOLL

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle Last) 2. DATE OF DEATH 3. TIME OF DEATH YEAR Ethel Martha Coakley 995 6:35 October a M 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign August 11,1922 North Carolina 578-60-9487 73 1 M 2 XF 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Clinton Prince Georges Southern Maryland Hospital Center 10a. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Prince George's Temple Hills 1 YES 2 NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 3904 Brinkley Road 20748 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMEO FORCES? 1 YES 2 YEO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea or No—If yea, specify Cuben, Maxican, Puerto Ricen, atc.) 14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married 1 YES 2 NO Specify: BY Specify: 3 X Widowed 4 Divorced Caucasian ETED 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only h Elementary/Secondary (0-12) College (1-4 or 5+) COMPL 12th Administrator Pluming & Heating 17. FATNER'S NAME (First, Middle, Last) 16. MOTNER'S NAME (First, Middle, Maiden Surname) Walker Effie Underhill Thomas BE 19m. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Donald M. Coakley, Jr 9574 Red Apple Lane Columbia, Md 21046-2044 20a_METNOD OF DISPOSITION
1 🔀 Burtal 2 🗆 Cremation 3 🗆 Removel from Stale 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE Cedar Hill Cemetery Nov. 1,1995 4 Donalion 5 Other (Specify). SUitland, Maryland 21. SIGNATURE OF FUNERAL SERVICE LIDERS 22. NAME AND ADDRESS OF FACILITY Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Rd Clinton, Md 23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Interval Between IMMEDIATE CAUSE (Final Onset and Death disease or condition resulting in death) CERTIFICATION Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other algorificant conditions contributing to death but not requiting in the underlying cause given in Part I. MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24s. WAS AN AUTOPSY PERFORMEO? 1 YES 2 1 NO OF DEATN? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) HOSPITAL:
1 in Inpetient 2 - ER/Outpetient 3 - DOA OTHER: 1 TES 2 NO 4 Nursing Home 5 Realdence 8 Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 20b. TIME OF INJURY 28d. DESCRIBE NOW INJURY OCCURED 1 Natural 5 Pending investigation 1 YES 2 NO 2 Accident 28a. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) ETED 6 Could not be 4 Homicide determined 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. (Check only one) 2 __ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day,

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	G PHYSICIA	er this cert	narked, or
	ATTENDIN	ECTOR: Aft	n 28 is n
	SPITAL OR	NERAL DIR	NT: If Item
	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hos	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detactive fined within 72 hours after death with the State Dept. of Health and Mental Miglene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

31. DATE FILED (Month, Day, Year)
OCT 3 0

	1. DECEDENT'S NAME (First, Middle, Last)		OL	RTIFICA	ALL OF	DEA	113		REG. NO			. TIME OF DEATN
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	4. SOCIAL SECURITY NUMBER 276-58-0065	5. SEX 6.	AGE (In yrs. lest	VRS. HON	THE DAYS	IF UNDER	24 HRS. MIN.	7 DATE	of BIRTH	1912	Country) Ohi	ACE (State or Foreign
	9a. FACILITY NAME (If not institution, give	9b.	CITY, TOWN	OR LOCATI	ON OF D	EATN	T 1 1 1	9c. COUN	TY OF DEA	ТН		
TOR	3808 Greenridge	Drive			Mon	rovia	ı			Fr	ederi	.ck
DIRECTOR	Maryland Fre	10a, STATE 10b, COUNTY 10c, CIT									1	DIA. INSIDE CITY LIMITS? YES 2 X NO
FUNERAL	3808 Greenridg	e Drive			10	i, zip cod 21	E 1770				S.A.	AT COUNTRY?
BY	11. MARITAL STATUS 1 Never Married 2 Married 3 XWidowed 4 Divorced	MED D	If yes, ap	CENDENT D HOCITY CUDE 1 2 ANO	n, Maxica	n, Puerto	N? (Specify Ye Rican, etc.)	a or No—	Black, 1	- American Indian, White, atc. White		
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COMPLET	17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S I						NER'S N			Sumame)		1408
BE	18a. INFORMANT'S NAME (Type/Print)	45	19b.	MAILIND ADD	RESS (Street	and Numbe					Code)	
2	Millard F. Clouse 3808 Greenridge Drive, Monrovia, Maryla								ry1ar	d 21770		
	20e. METNOD OF DISPOSITION 1								da, Maryland			
	22. NAME AND ADDRESS OF FACILITY Olin L. Molesworth, P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872											
	+ Torut L.	William	N		01in	L. I	Mole	swor			neral	
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BY PHYSICIAN: MEDICAL	23. PART See the disease, or heart failure immediate cause or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in deeth) LAST PART II. Other algnificant conditions. DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 ND 27. MANNER OF DEATN 1 Vietural 5 Pending Investigation investigation investigation determined 29a. CERTIFIER (Check only)	DUE TO (DI D. DUE TO	R AS A CONSED R AS A	DUENCE OF): DUENC	Olin 2640 Enter the mo Check only one PHER: Nursing Nor The 28c. IN. A, factory, offi	L. I Ricode of dy	given in CERTAI	SWOTI Road The accer Part I. 8 Oth 28d. DE	24a. WAS AI PERFO 1 VES OF (Specify) SCRIBE NOW CATION (Street or Town, State	N AUTOPSY RMED? 2 NO	24b. V	VERE AUTOPSY FIN MAILABLE PRIOR TO COMPLETION OF CA

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF OEATH (ITEM 27) (Typo, Print)

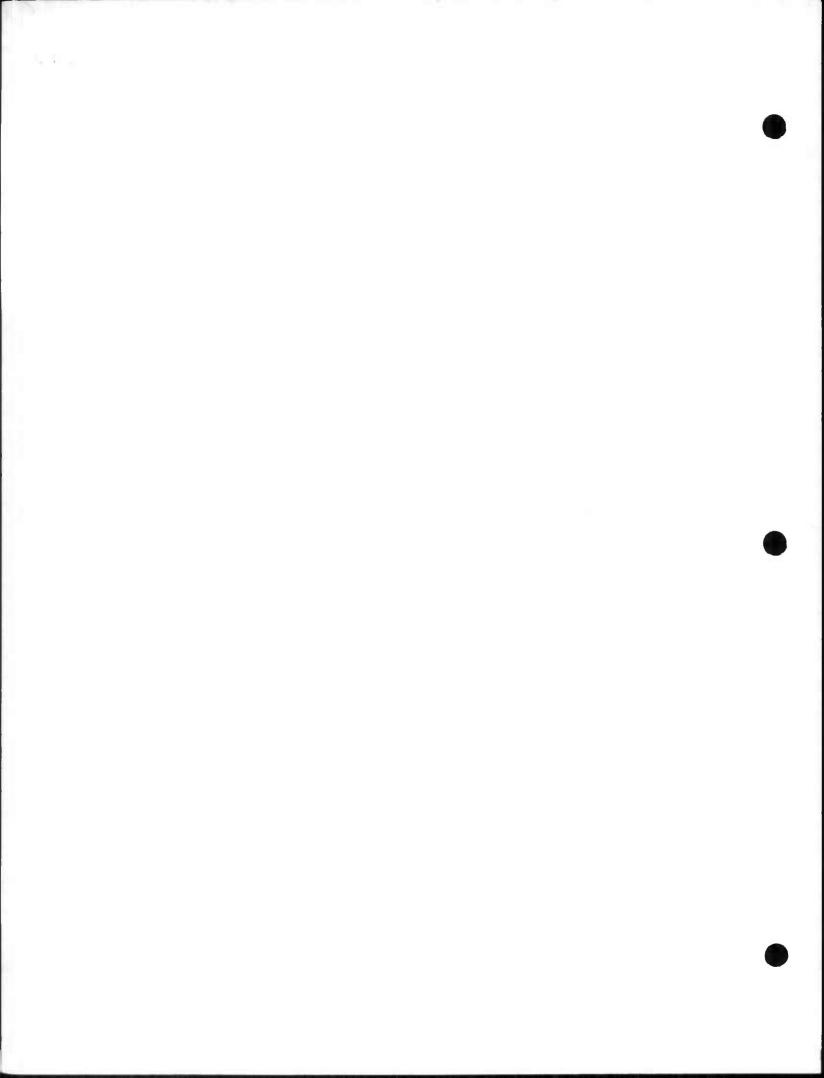
ARTHAR G. MANANO, NO. 187 THOMAS JOINSON DR. FREDENIN,

32. REGISTRAR'S SIGNATURE

5, ____

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page to	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral direct	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
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	1 - STATE REGISTRAR	STATE OF MARYLAND			OF HEALTH		MENTAL HYGIENI REG. NO.	E		
	1. DECEDENT'S NAME (First, Middle, Last)	01:0					2. DATE OF OEATN DA	Y YEA	3. TIME OF DEATN	
	Thomas 4. SOCIAL SECURITY NUMBER 5.	Clifton SEX 8. AGE (in yrs.	last hirthday)	IF UNDER 1	YEAR IF UNDER	SR	October 2			
		M 2 □ F 55			DAYS HOURS	MIN.	Nov 17,19	1. BIRTHPLACE (State or Foreign Country) Maryland		
	9a. FACILITY NAME (If not institution, give street	and number)		9b. CITY, 1	OWN OR LOCATI	ON OF DE		9c. COUNTY OF DEATN		
Q R	Northampton Manor	Nursing Cent	er	F	rederic	k		Frede	erick	
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		10c, CIT	Y, TOWN OR	LOCATION				10d. INSIDE CITY	
E	Maryland Fred	lerick		Fre	derick				LIMITS?	
1AL	10e. STREET AND NUMBER				101. ZIP COD			10g. CITIZEN C	F WHAT COUNTRY?	
FUNERAL		ly Drive, Apt EE104				02			S.A	
BY FU	11. MARITAL STATUS 1 Never Married 2 K Married 3 Widowed 4 Divorced	2. WAS DECEDENT EVER IN U.S. FORCES? 1 YES 2 O IF YES, GIVE WAR OR DATES	ARMED ANO	H !	AS DECENDENT (yes, specify Cubs YES 2 1 NO	in, Maxican	C ORIGIN? (Specify Yea , Puarto Rican, etc.)	В	ACE — American Indian, leck, White, atc.	
	15. DECEDENT'S EDUCATE (Specify only highest grade con		DECEOENT'S	USUAL OCC	UPATION ring most of workli		16b. KINO OF BUS	INESS/INDUSTR	Y	
9		College (1-4 or 5+)	life. Do NOT us	se retired.)		rigi	Tomdos			
OMPLETED	Nurser 17. FATHER'S NAME (First, Middle, Last)					11-2	Landsc			
E C	01.0	Owen	CARL	TSLE		rion	NE (First, Middle, Malden S		CHOLSON	
D BI	19a. INFORMANT'S NAME (Type/Print)						oute Number, City or Town			
10	Mrs. Sarahlea Carl						104, Frede			
examiner must be notified at once. TO BE COM	20a, METNOD OF DISPOSITION 1 Burial 2 Cremation 3 Removal 4 Donation 6 Other (Specify)	from State 20b.PLAC	CE AND DATE	ther place)	ION (Name of	Oot	OATE 20c. LOC	ATION - City of	r Town, State rg, Maryland	
201	21. SIGNATURE OF FUNERAL SERVICE LICENS	SEE 1	13Dar E	22. N/	ME AND AODRE	SS OF FAC	ILITY			
Eexa	Kotth hover	Cherry) NO	0706				ford P.A.			
	23. PARY I. Enter the diseases, or com	plicetione that ceused the	deeth. Do r	not enter th	ne mode of dy	Ing, such	street, Fre	ederick	Approximate	
event, the medical	IMMEDIATE CAUSE (Finel disease or condition resulting in death)	Sould CL DUE TO (OR AS A CONS	rea	0	lune	_		9	Interval Between Onset and Death	
	Sequantially list conditions, if any, leading to immediate cause. Enter UNDERLYING									
CERTIFICATION	CAUSE (Disease or Injury that initiated events resulting in deeth) LAST	DUE TO (OR AS A CONS	SEOUENCE OF	ግ ፡						
SAL	PART II. Other eignificent conditions of	ontributing to deeth but no	t resulting i	n the unde	erlying ceuse of	given in F	Part I. 24a. WAS AN / PERFORI	MED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE	
BY PHYSICIAN: MEDI								1	OF DEATH?	
AN:	25. WAS CASE REFERRED TO MEDICAL									
SICI	EXAMINER?	OSPITAL:	3 □ DO4	OTHER:	28. PLACE OF O		Other (Specify)			
H	27. MANNER OF DEATH	28s. OATE OF INJURY (Month, Day, Year)	28b. TiMi	-	Bc. INJURY AT	aldence a	28d. DESCRIBE HOW IN	JURY OCCURED		
BY F	1 Natural 5 Pending investigation			M	WORK?] NO				
ZE IS	3 Suicide 6 Could not be 4 Homicide detarmined	28a. PLACE OF INJURY — At building, atc. (Specify)	home, farm, e	treet, factor	, offica		26f. LOCATION (Street ar City or Town, State)	nd Number or Rur	al Route Number,	
D BE COMPLETED		t: To the best of my knowledge, on the basis of examination and/o							e(a) and manner as stated.	
BE	29b. SIGNATURE AND TITLE OF CERTIFIER	11				ENSE NUM			IED (Month, Day, Year)	
D 0	30. NAME AND ADDRESS OF PERSON WHO CO	Anna Carres on an		0.1.0	D1	13971		October 26,1995		
	Robert L. Kaufmann	V			Stroot	Engl	oriols Ma-	arlan J	21.701	
	31. DATE FILED (Month, Day, Year)	M.D., 300 We	O IVI	iitll 3	orreer,	ттес	erick, Mai	гутапа	Z1/U1	
	OCT 2 7 1995	Jana Dandes	Mardall	1						



FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

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Harry Linwood Carter Jr 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR DAYS HOURS 214-32-7249 1 X M 2 - F 90 YRS. 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATN DIRECTOR permit, Pages 1, 2, 3 5782 S. Hawthorne Avenue (AT HOME Rock Hall RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT 10c. CITY, TOWN OR LOCATION Maryland Kent Rock Hall FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE burial-transit 5782 South Hawthorne Avenue 21661 be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuban, Mexican, Puarto Rican, etc.) FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 1 Never Married 2 Married 1 YES 2X NO Specify: BY 3 X Widowed 4 Divorced use as the 15. DECEDENT'S EDUCATION 18a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) (Specify only highest grade completed) 山 funeral director, page 5 should be detached for Elementary/Secondary (0-12) College (1-4 or 5+) COMPL 6 Waterman be notified at once, 17. FATHER'S NAME (First, Middle, Last) Harry Linwood Carter Sr 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Mrs. Lynn Wahawiz 20s. METHOD OF DISPOSITION
1 Disposition 3 Removal from State
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of Раде 6 тау must Obmetery - October 13, 1995 examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY
Fellows - Wells Funeral Home death. William L. King Jr physician and completely filled in by the ne prior to burial, cremation, or removal. the medical 23. PART I. Enter the diseases, or complications that caused the death princt enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fellure. List only one cause on acci-IMMEDIATE CAUSE (Final disease or condition resulting in death) Arteriosolinotic Cardio Vascular event, DUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury / the attending phy d Mental Hygiene p DUE TO (OR AS A CONSEQUENCE OF): that initiated eventa reaulting in death) LAST -0 PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL een signed by the Hapertusins shows any has been of h DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) item this certificate h with the State [HOSPITAL OTHER: 1 YES 2 NO Inpetient 2 ER/Outpetient 3 DOA OR ATTENDING PHYSICIAN: 4 Nursing Nome 54 Residence 8 Other (Specify) 6 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? marked, Natural Natural 5 Pending 1 YES 2 NO L DIRECTOR: After the bours after death v BY 2 Accident 28a. PLACE OF INJURY — At home, farm, street, tectory, office building, etc. (Specify) 3 Suicide COMPLETED 8 Could not be 4 Nomicide 200 Hem 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and menner as stated. THE HOSPITAL OF THE FUNERAL DE TO THE HOSPITAL
TO THE FUNERAL I
De filed within 72 h
IMPORTANT: If I 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER B D00354 0 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

eucaun

32. REGISTRATI'S SIGNATURE
GUNA DAY door

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

Brown Str. C

2. DATE OF DEATH 3. TIME OF DEATH 1995 October 11, 0825 hrs 7. DATE OF BIRTN 8. BIRTNPLACE (State or Foreign June 8, 1905 Maryland 9c. COUNTY OF DEATN Kent 10d. INSIDE CITY 1 X YES 2 NO 10g. CITIZEN OF WHAT COUNTRY? United States 14. RACE — American Indian, Black, White, atc. White 16b. KIND OF BUSINESS/INDUSTRY Boating 18. MOTHER'S NAME (First, Middle, Maiden Surname) Annie May Gadd 21661 20839 Bayside Avenue, Post Office Box 123, Rock Hall, Maryland 20c. LOCATION - City or Town, State DATE Rock Hall, Maryland Maryland Route 20, Rock Hall, Maryland Approximata Interval Batween Onset and Daath chas distant 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? PERFORMED? 1 | YES 2 | 10 1 YES 2 NO 28d DESCRIBE NOW INJURY OCCURED 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 29d. DATE SIGNED (Month, Day, Year) 101669;

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

_	TICOTOTT DATE			_	10011111	10/116				110				
	1. DECEDENT'S NAME (First	, Middle, Last)								2. DATE OF D	EATH DAY		YEAR	3. TIME OF DEATH
	Charles C					CARE	ΣY			Oct.	15		995	5:02 a M
	4. SOCIAL SECURITY NUME		5. SEX	S. AGE (In yrs. i	ast birthday)	IF UNDER	1 YEAR	IF UNDER	24 HRS.	7. DATE OF B			8. BIRTH	IPLACE (State or Foreign
	040 46 76	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	1 XM 2 □ F	76	YRS.	MONTHS	DAY8	HOURS	MIN.	(Month, Day		Country)		
	213-16-40				05:0079	9b. CITY, TOWN OR LOCATION OF DEATH				2/15/18 Baltime			timore,MD	
~	9s. FACILITY NAME (if not institution, give street and number)						*		ON OF DE	AIN				
DIRECTOR	Easton Memorial Hospital					La	Easton,MD Talbot							
5	RESIDENCE OF DEC	10b. COUNTY	,		100 CIT	Y, TOWN O	OB LOCA	TION						10d. INSIDE CITY
2	MD	1100						e, MI)					LIMITS?
														1 YES 2 NO
FUNERAL	10e. STREET AND NUMBER						10	. ZIP COD						WHAT COUNTRY?
H	P.O. Box	212						216)T/			U	SA	
5	11. MARITAL STATUS		12. WAS DECEDEN FORCES? 1	TEVER IN U.S.	ARMED					NC ORIGIN? (Sp		or No-	14. RAC	E — American Indien, k, White, etc.
	1 Never Married 2		IF YES, GIVE V		JNO			ecity Cube		n, Puerlo Rican	, atc.)		Spec	
B	3 Widowed 4 Dive	breed	WII					X		,				ack
	15. DEC	EDENT'S EDU	CATION	16a. I	DECEDENT'S	USUAL O	CCUPATI	ON		16b. KINI	D OF BUS	INESS/INC	DUSTRY	
	(Specify on Elementary/Secondary (ly highest grade	Coffege (1-4 or 5		(Give kind of life. Do NOT u	work done se retired.)	during me	ost of worki	ng					
COMPLETED	1 O	0-12)	Conege (14 or 5	"	Custo	odiar	1			Man	ufac	turi	ng	
S	17. FATHER'S NAME (First, A	diririin I net)						I 10 MOT	HED'S NA	ME (First, Middle	Mairian :	Surnama)		
	II. PATTLES & HAME IT ISS., IV	vidure, Ediety										,		
BE	Thomas Co	rey								Vesse				
0	19a. INFORMANT'S NAME (BOX				Route Number, C eville,		216		
-	Helen Aye	ers			r.U.	DO	. 21.	2 (6	HILL	eville,	UID	210	11/	
	200: METHOD OF DISPOSIT	ION	oval from State		E AND DATE			ame of		DATE	20c. LO	CATION -	City or To	own, State
	4 Donetion 8 Dother				itus 1			Parl	ζ	10/20) Ba	ltin	ore.	MD
	21. SIGNATURE OF FUNERA	LOSHWICE LIC	ENSEE			22.	NAME A	NO ADDRE	SS OF FA				,	
		I				7				n Funer				
	10	1								_ Dove			990:	
	23. PART I. Enter the d shock, or h		List only one car			not enter	the me	ode or dy	mg, auc	n as cardiac	or reshi	ratory ar	rest,	Approximate interval Between
	IMMEDIATE CAUSE (FI	nal	1 -		^	L	d.	^	*		1			Onset and Death
	disease or condition resulting in death)	\rightarrow	Arlar	41 50	Cro	tic	Ce	vide	NUA	sculo	v 1	Sy	10-	so Years
			DUE TO	(OR AS A CONS	SEQUENCE C	F):								
z			h											
0	Sequentially list condi- if any, leading to imme		DUE TO	(OR AS A CONS	SEQUENCE C	IF):								
A	cause. Enter UNDERLY	ING												
E	CAUSE (Disease or Injuthat Initiated events	ury	DUE TO	(OR AS A CONS	SEOUENCE C	NF):								
F	resulting in death) LAS	ST	4											
CERTIFICATION			0.						*)					
	PART II. Other algnific	ent condition	a contributing to	deeth but no	t rasulting	In the u	nderlylr	ng ceuse	given in	Part I. 24s	. WAS AN		24	b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO
EDICAL										1	YES 2	* *		COMPLETION OF CAUSE OF DEATH?
														1 YES 2 NO
2	DID TOBACCO U	ISE CONT	PIRLITE TO CA	LISE OF DE	ΔTH Y	ES 🖂	NO F	T UNG	CERTAI	N DY				
PHYSICIAN:	25. WAS CASE REFERRED		I CALLED CA		ACE OF DEA				CENTAI	1 20				-
Ö	EXAMINER?	TO WILDIONE	HOSPITAL:		6.40	OTHE	R:		700					
YS	1 TYES 2 NO		1 Inpatient 2				-		lesidence	8 Other (Sp				
T	27. MANNER OF DEATH		28e. DATE Of (Month, I	F INJURY Day, Ybar)	28b. Til	ME OF JURY	28c. IN	JURY AT ORK?		28d. DESCRI	BE HOW I	NJURY OC	CURED	
ВУ	1 Naturel 5 _	Pending Investigation				М	1 🗆	YES 2	NO					
	a [] a 1-14	Could not be	28e. PLACE (OF INJURY - At , atc. (Specify)	home, term,	street, tac	ctory, offi	ce			N (Street e	and Numbe	r or Rural	Route Number,
TED	4 Homicide	determined		, ,, ,						1 1	,,			
COMPLET	29e. CERTIFIER	TIEVING BUVE	Class To the heat o	f my knowledge	double name	and at the	No. de	a and alan	a and du	to the same to) and man		114	
N P	CORECA DINY		ICIAN: To the best o											(a) and manner as stated
Ö	77			examination and/	or investigati	on, in my	ориноп,	death occ	JI'W DW CIN	r time, date end	piace, en	d que to t	ne ceuse	(e) end manner ee stated.
ш	28b. SIGNATURE AND TETL	E OF CERTIFIE	n The	27				295 LIC	ENSE NU	MBER		29d. DA	TE SIGNE	D (Month, Day, Year)
0								P	24	167			Oli	6175
2	30. NAME AND ADDRESS O									04 55 :				
	L. Thomas	s Divi	lio, MD	404 Ma	rvel	Ct.	Eas	ton,	MD	21601				
4	31. DATE FILED (Month, Day OCT 1	, Ybar)	32. REGISTR	AR'S SIGNATUR	E									
	u ner 1	7 95	Ju	ha Sacrids	n- Pan	delle								
	M 001 Y	0.0	//											

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TOTHE HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be flaw within 72 hours after this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be flaw within 72 hours after the bunal-transit permit. Pages 1, 2, 3 should be flaw within 72 hours after the bunal-transit permit. Pages 1, 2, 3 should be flaw within 72 hours and the 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR			EHIIF	ICALE	UF	DEAL	I H	F	REG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last)	TAN OH	EGOWT A						2. DATE OF MONTH	DA		YEAR	3. TIME OF OEATH	
	GEORGE WILI		ECCHIA					-	OCTOB		, 19		1:00 P. M	
			. AGE (In yrs. I		IF UNDER 1	DAYS	IF UNDER	24 HRS.	7. DATE OF (Month, De	BIRTH ny, Year)		8. BIRTH Countr	PLACE (State or Foreign y)	
	579-20-0231	1 X M 2 - F	71	YRS.							924	WAS	HINGTON, DC	
~	9a. FACILITY NAME (If not institution, give street end number)					TOWN C	OR LOCATIO	ON OF DEA	ATH		9c. COL	9c. COUNTY OF OEATH		
0	6705 Oakland Avenue					ivei	rdale	2		- 1	Pr	ince	George's	
	RESIDENCE OF DECEDENT 100. STATE 10b. COUNTY	,		I the CIT	Y. TOWN OF	D L OCAT	HON							
DIRECTOR	Maryland Prince George's Capital Heights										10d. INSIDE CITY LIMITS?			
	10e. STREET AND NUMBER	Cap	ıtaı		LGDES						1 YES 2 X NO			
FUNERAL						101							VHAT COUNTRY?	
N N	6707 Drylog Street 11. MARITAL STATUS 12. WAS DECEDENT, EVER IN U.S. AR				T		2074						States	
	1 Never Married 2 Merried	FORCES? 1 2	YES 2	NO NO	H.	yes, spe	ecify Cubar	n, Mexican	C ORIGIN? (S , Puerto Rice		or No-	14. RACE Black	— American Indian, t, White, etc.	
ВҰ	3 🕅 Widowed 4 🗌 Divorced	1943 to 1			1	YES	2 X) NO	Specify:				Specif	w. White	
0.	15. DECEDENT'S EDUC	CATION		ECEDENT'S	USUAL OC	CUPATIO	ON		165 (1	ND OF BUS	INESS/IN	DUSTRY	WILLE	
	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5 +)		Give kind of a	vork done du se retired.)	uring mo	st of workin	g				0001111		
7	9	Conege (1-4 or 5+)	P1	umber					P11	umbin	e Tr	dust	rv	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)						18. MOTH	IFR'S NAM	E (First, Midd				~)	
	Fred Checchia								Raffo	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Juliani			
8	19a. INFORMANT'S NAME (Type/Print)		1	9b. MAJLING	ADDRESS	(Street e			oute Number,	City or Town	State 7	to Codel		
2	Yolanda Zimmerman								iverda				20737	
	200. METHOD OF DISPOSITION							c, K	_	_				
	1 (V Buria) 2 Cremation 3 Removal from State													
- 1	4 Donotton 5 Other (Specify) Fort Lincoln Cemetery 10/20/95 Brentwood, Maryl 21. SIGNATURE OF FUNERAL SERVICE THE TOTAL SIGNATURE OF FUNERAL SERVICE THE SIGNATURE OF FUNERAL SERVICE THE SIGNATURE OF FUNERAL SERVICE THE SIGNATURE OF FUNERAL SERVICE THE SIGNATURE OF FUNERAL SERVICE THE SIGNATURE OF FUNERAL SERVICE THE SIGNATURE OF FUNERAL SERVICE THE SIGNATURE OF FUNERAL SERVICE THE SIGNATURE OF FUNERAL SERVICE THE SIGNATURE OF SIGN										Maryland			
	5	///		_	For	rt I	inco	ln F	unera.					
_		XXV 1	OOK		340)1 E	31ade	nsbu	rg Rd	., Br	entv	vood,	MD 20722	
	23. PART I. Enter the diseases, or shock, or heart failure. IMMEDIATE CAUSE (Final	List only one cause	on each lin	e.			ds of dyl	ng, such	ss cardiac	or respir	atory sr	rest,	Approximats Interval Between Onset and Death	
	disease or condition resulting in death)	METASTA	TIC CA	NCER	– LUN	NG							9 MONTHS	
		DUE TO (O	R AS A CONSI	EQUENCE OF	F):									
N	Sequentially list conditions,	o												
CERTIFICATION	If any, leading to immediate couse. Enter UNDERLYING	DUE TO (OI	R AS A CONSI	EQUENCE OF	7):									
일	CAUSE (Disease or injury	DHE TO (O	R AS A CONSE	COLLENCE OF										
Ē	that initiated events resulting in death) LAST	502 10 (0)	n AS A CONS	GUENCE O	-):									
- 英川		1												
	PART II. Other significant condition	s contributing to de	ath but not	resulting	n the und	derlying	causa g	iven in P	Part I. 24	. WAS AN		24b.	WERE AUTOPSY FINDINGS	
EDICAL										PERFORM			AMILABLE PRIOR TO COMPLETION OF CAUSE	
									_ ''	YES 2	XNO		OF DEATH?	
Σ	DID TOBACCO USE CONTI	RIBUTE TO CALL	SE OF DE	ATH YE	S \square N	ОГ	LINC	ERTAIN	RT				1 YES 2 NO	
A	25. WAS CASE REFERRED TO MEDICAL			CE OF DEAT			DINC	FUINIIA						
Sic	EXAMINER? 1 YES 2 X NO	HOSPITAL:		T	OTHER	:	V .	alden - A	Other (St					
PHYSICIAN	27. MANNER OF DEATH	28a. DATE OF IN.	JURY	28b. TIM	E OF	28c, INJI	URY AT	7	28d. DESCRI		JURY OC	CURED		
	1 X Natural 5 Pending	(Month, Day,	Year)	INJ	URY M	WO	RK?	- 1						
BÝ	2 Accident Investigation 3 Suicide 8 Could act be	28e. PLACE OF II	NJURY At h	ome, term, a	treet, tactor				28t. LOCATIO	N (Street er	nd Numbe	r or Bural B	oute Number	
	4 Homicide 8 Could not be	building, ato	(Specify)					- 1		wn, State)			,	
COMPLET	29e, CERTIFIER													
A P	(Check only one)													
8	2 MEDICAL EXAMINE	. On the basic of exam	inition end/or	investigatio	n, in my op	inion, di	esth occur	ed at the ti	ima, date and	placa, end	due to t	he ceuse(s)	end manner ee stated.	
8	296. SIGNATURE AND TITLE OF CERTIFIER	1000-	/				29c. LICE	NSE NUME	BER		29d. DAT		(Month, Day Year)	
ρ 2	Mullin O. C	wer (r	~				255	5)	1 5			10/	4 12	
	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE	OF DEATH (ITI	1 (Type,	Print)	. 6	Ja G	hee	ule	D	MI	2	OCCE	
	OCT 23-1995	MENTERSTRANS	SIGNATURE) -	***					

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DIVISION OF VITAL RECORDS, P.O. BOX 6

	1 - FOR STATE REGISTRAR	STATE OF MARYLA		TMENT OF H		MENTAL HYGIEN				
	1. DECEDENT'S NAME (First, Middle, Last) JOSEPHNE	CAR	053 (175	772		2. DATE OF DEATH	AY, Y	3. TIME OF DEATH		
		5. SEX 6. AGE (In	yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	195	BIRTHPLACE (State or Foreign		
	578 22 3441	1 - M 2 XF 7	3 YRS.	MONTHS DAYS	HOURS MIN.	(Month, Gey, Year)	22	Washington, D.C.		
_	9s. FACILITY NAME (If not institution, give street			9b. CITY, TOWN	OR LOCATION OF D		9c. COUNTY			
DIRECTOR	manon Care Nuxtry home largo manyland PG									
REC	10s. STATE 10b. COUNTY		10c. CITY	, TOWN OR LOCAT	TION					
	District of Columb	ia			nington			LIMITS?		
FUNERAL	20 Seaton Plac	e. N.W. #1		101	. ZIP CODE	0.1		ed States		
ON	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECEMBENT OF HISDAMIC ORIGINAL CONCINE. AS A BACK									
BY F	1 Never Merried 2 Merried 3 Widowed 4 Divorced	FORCES? 1 YES			ecify Cuban, Maxic 2 X NO Speci	en, Puerio Ricen, atc.) Hy:		Black, White, etc. Specify:		
ED E	15. DECEDENT'S EDUCA	TION	16a. DECEDENT'S	USUAL OCCUPATION	N .	16b. KIND OF BU	PINESS INOUS	Black		
ETI	(Specify only highest grade co	mpleted) College (1-4 or 5+)	(Give kind of w life. Do NOT us	rork done durina ma	st of working	100. KIND OF BO	SINESS/INDUS	101		
COMPLET		2		Clerk	Governm	nent				
8	17. FATHER'S NAME (First, Middle, Last)				16. MOTHER'S NA	AME (First, Middle, Maiden				
BE	Fred Edward 19a. INFORMANT'S NAME (Type/Print)	Walker	10h MAII ING	ADORESS (Street of	ad Alumbas as Ount	Mable Ho Route Number, City or Tow				
5	Ora L. Murray									
	20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State									
	Gate of Heaven Cemetery 10/16/95 Silver Sp									
	Stewart Funeral Home									
	23. PART Venter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or reapiratory arrest, Approximate									
NO	immediate cause (Final disease or condition resulting in death) Sequentially list conditions,	DUE TO (OR AS A C	STATE ONSEQUENCE OF NOME	7 C			1 To 6	Approximete interval Batweer Onset and Dasti		
CERTIFICATION	Sequentially list conditions, if eny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): OUE TO (OR AS A CONSEQUENCE OF):									
SAL	PART II. Other aignificent conditions	contributing to death but	not resulting in	n the underlying	g ceuee given in	Part I. 24a. WAS AN PERFOR		24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO		
EDIC		ow my	2 D	NR.		1 🗆 YES 2	>0 0	OF DEATH?		
¥ ::	DID TOBACCO USE CONTRIB	BUTE TO CAUSE OF	DEATH YE	S I NO I	UNCERTAI	N M	/	1 TES 2 NO		
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL	26	. PLACE OF DEAT		ONCERIM					
YSIC	- %	OSPITAL: Inpetient 2 ER/Outpet	lent 3 🗆 DOA	OTHER: 4 Whursing Hom	e 5 🗆 Realdence	6 Other (Specify)				
PH	27. MANNER OF DEATH 1 Solution 5 Pending	26s. DATE OF INJURY (Month, Day, Year)	28b. TIME	JRY WO	URY AT RK?	26d. DESCRIBE HOW II	NJURY OCCUR	ED		
à	2 Accident Investigation	26s. PLACE OF INJURY	At home form of		ES 2 NO					
	3 Suicide 6 Could not be determined	building, atc. (Specify	/)	reer, rectory, office	,	28f. LOCATION (Street a City or Town, State)	ind Number or F	Rural Route Number,		
3	29s. CERTIFIER (Check only	N: To the best of my knowled	dge, daath occurre	d at the time, date	and place, and due	to the sever(s) and more				
COMPLETED	one) 2 MEDICAL EXAMINER:	On the besis of examination s	and/or Investigation	, in my opinion, d	eath occured at the	time, data and place, an	d due to the ce	ruse(s) and menner as stated.		
BE C	296. SIGNATURE AND TITLE OF CERTIFIER		070	20	29c. LICENSE NU			GNED (Month, Day, Year)		
TO B	7.7-K4014	D	Pari	are	D-31	1525	10	-11-95		
	30. NAME AND ADDRESS OF PERSON WHO C	COMPLEXED CAUSE OF DEAT	Kead	Print) #2	20;	BOWLE	W	D-20716.		
	31. DATE FILED (Month, Oay, Year)	32/REGISTRAR'S SIGNAT	Kerlet							

Lane III

AN:	CTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlal-transit permit, Pages 1, 2, 3 should	e State Dept. of Health and Mental Hygien	28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HOSPITAL OR ATTENDING PHYSICIAL	THE FUNERAL DIRECTOR: After this certifi	be filed within 72 hours after death with the	MPORTANT: If item 28 is marked, or

	ITEM1,g-730,12-6-95	,perf.h.,dl	k										
	1 - STATE REGISTRAR	STATE OF N							MENT	TAL HYGIEN	E		
	REGISTRAR 1. DECEDENT'S NAME (First, Middle, Last)	-	С	ERTIF	ICATI	OF	DEA	ГН		REG. NO.			
	CHARLES	Ε.			С	OLB:	ERT	OC	MO	NTH DA BER 13	, 19	995	5:02 P M
	4. SOCIAL SECURITY NUMBER 214-14-3948 214-11-3948	5. SEX 1 💢 M 2 🗌 F	6. AGE (In yrs. Ia	S YRS.	IF UNDER	1 YEAR DAYS	IF UNDER	MIN.	July	TE OF BIRTH		8. BIRTH	PLACE (State or Foreign
	9e. FACILITY NAME (If not institution, give s	treet end number)			9b. CITY	, TOWN C	OR LOCATI	ON OF DE	EATH		9c, COL	JNTY OF D	EATH
TOR	PRINCE GEORGES	HOSPIT	AL CEN	TER	СН	EVE	RLY				PR:	INCE	GEORGES
DIRECTOR	Maryland Prince	George's		10c. Cf1	Y, TOWN (OR LOCAT		Capito	ol He	eights			10d. INSIDE CITY LIMITS? 1 XXYES 2 NO
FUNERAL	100. STREET AND NUMBER 4911 Emo Street					101	. ZIP COD	207	743			U.S.A.	WHAT COUNTRY?
뿔	11. MARITAL STATUS	12. WAS DECEDEN	T EVED IN II S A	DMED	12	WAS DEC	ENDENT (CINIS (Consider Man			
B	1 X Never Merried 2 Merried 3 Widowed 4 Divorced	FORCES? 1 IF YES, GIVE W	YES 2 X	NO	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No— It yee, specify Cuben, Mexican, Puerto Ricen, etc.) 1 YES 2 YVNO Specify:					Black Speci	:— American Indian, t, White, etc.		
0	15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	16a, D	ECEDENT'S	USUAL O	CCUPATIO	ON of works	00		16b. KIND OF BUS	SINESS/IN	IDUSTRY	
COMPLETED	Elementary/Secondery (0-12)	College (1-4 or 5 +		e. Do NOT u	se retired.)	ourny mo	St Of WORK	ng		112 1 6 1	-		
MP	10th grade			Stı	ident_					High Sch			
	17. FATHER'S NAME (First, Middle, Last) Eugene L.	Colbert					18. MOT	HER'S NA		Alberta (S	
B	19e. INFORMANT'S NAME (Type/Print)		1	9b. MAILIN	ADORES:	S (Street e	nd Numbe	r or Rural i		umber, City or Town			
일	Mr.Eugene L. Colbert	(Father)		4911 E	imo St	reet	Capi	tol H	leigh	nts, Mary	land	20743	
	20a. METHOD OF DISPOSITION 1 Burlet 2 Cremation 3 Rem	oval from State	20b. PLACE cemetery, ci	rematory or i	other place)				1	1		- City or To	wn, state aryland
Ιi	4 Donation 5 Qther (Specify)	Acc	Harmo	ny Men				SS OF FA		7 7 7 3		Ci , Inc	il y laila
	15	11/11	10							me, Inc.		_	
	700	ough	1/_										C. 20019
	23. PART i. Enter the diseasea, or c shock, or haart fallura.	Complications the List only one can	t caused the d se on each lin	leath. Do la.	noi anter	the mo	de of dy	ing, suc	h ss c	ardisc or reapi	ratory a	rreal,	Approximata intarvai Between
	iMMEDIATE CAUSE (Final disease or condition		. 4	1 -		~	1	d	0	Dei-			Onset and Death
	disease or condition resulting in dasth) DUE TO (OR AS A CONSEQUENCE OF):												
NO.	Sequantially list conditions,	QUENCE O	OF):										
CAT	if any, laading to immediata cause. Entar UNDERLYING CAUSE (Disease or injury												
ERTIFICATION	thet initiated eventa resulting in death) LAST	DUE TO	(OR AS A CONSI	EOUENCE C	OF):								
S		d									V.		
SAL	PART II. Other algnificant condition	s contributing to	death but not	reauiting	in tha u	ndarlyin	g cause	givan In	Part i.	24s. WAS AN PERFOR	AUTOPSY	24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
MEDICAL										1 YES 2	□ NO		OMPLETION OF CAUSE OF DEATH?
	DID TOBACCO USE CONT	DIRLITE TO CA	LISE OF DE	ATLI V	ES 🗆	NO F	1 LINI	CERTAII	N D				YES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL	KIBUTE TO CA		CE OF DE				SERIAII			_		
Sici	EXAMINER? 1 X YES 2 NO	HOSPITAL:	ER/Outpatient	3 🗆 DOA	OTHE		w 5 □ B	esidence	6 1 0	ther (Specify)			
`	27. MANNER OF DEATH	28e. DATE OF	INJURY	28b, TII	AE OF	28c. INJ	URY AT		Y -	DESCRIBE HOW I	NJURY O	CCURED	
ВУР	1 Netural 5 Pending 2 Accident Investigation	(Month, D	13.95	1 4	JURY JA	1 🗆	YES 2	NO		DI 816	CT	Stt	0-1-
	3 Suicide 6 Could not be	26e. PLACE O	F INJURY — At I	ome, ferm,	street, fac	tory, offic	•		- 0	OCATION (Street of		_	
ETE	4 Homicide determined		9	122	ET				ar	elimen	TA	E16	MOST.
COMPLETED	(oriotic orin)	CIAN: To the beat of											
8	2X MEDICAL EXAMINE	R: On the beels of e	xamination end/o	r investigati	on, in my	opinion, d	leath occu	ired at the	time, d	late end place, en	d due to	the ceuse(e	e) end manner as stated.
BE	29b. SIGNATURE AND TITLE OF CENTIFIED	1					29c. LIC	ENSE NU	MBER		29d. DA	TE SIGNED	(Month, Day, Year)
2	30. NAME AND ADDRESS OF PERSON WIL	OTOMPI ETER CALL	SE OF ACATU AT	EM on a -	a Drivet	-	Lo.	C.M	F.	OC'	COBI	ER 14	4. 1995
	The same and northeast of Felsolving	X - A						D -					1 21225
	31. DATE FILED/(Month, Day, Year)	32. REGISTRA	IR'S SIGNATURE	Per	in_S	rre	er.	Ral	T 11	nore.	Mary	Land	d 21201
	DCT 241995 July	develope	Kardall										
-													DUMH. 16 Pay 1/80

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should clean with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	- 5
DIVISION OF VITAL RECORDS, P.O	AL DR ATTENDING PHYSICIAN: The law requires that the death cert	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending be filed within 72 hours after death with the State Dept. of Health and Mental Hydis	tead

	1 - FOR STATE REGISTRAR	ATE OF MARYLAND / CE	DEPARTMENT OF		MENTAL HYGIEN	E			
- 3	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH MONTH DA	Y YEAR	3. TIME OF DEATH		
	SHAWN .T. 4. SOCIAL SECURITY NUMBER 5. SEX	CALLOWAY		_ 1		22,199			
	221 27 4055	6. AGE (In yrs. lest to	YRS. WONTHE DAY	S HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	Co	RTHPLACE (State or Foreign ountry)		
	9a. FACILITY NAME (If not institution, give street and	- 21		/N OR LOCATION OF DE	Feb. 21, 197	9c. COUNTY O	Wport News, VA.		
TOR	RT.495 & RT.414		OXON	HILL		PRINCE	E GEORGES		
DIRECTOR	Virginia 106. COUNTY		Newport N				tod. INSIDE CITY LIMITS? t XYES 2 NO		
IAL I	toe, STREET AND NUMBER			10I. ZIP CODE		10g. CITIZEN C	OF WHAT COUNTRY?		
FUNERAL	1024-30th Street			23607		U.S.	.A.		
B	t 12 Never Married 2 Married FO	AS DECEDENT EVER IN U.S. ARM DRCES? 1 TYES 2 X NO YES, GIVE WAR OR OATES	II yes	DECENDENT OF HISPAN, specify Cuban, Maxicar YES 2 X NO Specify	n, Puerto Rican, etc.)		ACE — American Indian, Heck, White, etc. Specify:Black		
띹	15. DECEDENT'S EDUCATION (Specify only highest grade complete	16a. DECI (Give	EDENT'S USUAL OCCUP		16b, KIND OF BUS	SINESS/INDUSTR	Y		
COMPLETED		ge (1-4 or 5 +)	o NOT use retired.) tudent	•	Educati	On			
OMF	17. FATHER'S NAME (First, Middle, Last)	Cars .	- Cuacifo	18. MOTHER'S NAI	ME (First, Middle, Maiden				
	Robert H. Calloway				Calloway n		Ley		
TO BE	19a. INFORMANT'S NAME (Type/Print)	19b.	MAILING ADDRESS (Str	eet and Number or Rural F	Route Number, City or Tow	n, Stere, Zip Code)		
	Sheila Calloway			treet. New					
	20a. METHOD OF DISPOSITION 1 X Burial 2 Cremation 3 X Temoval Iro 4 Donation 5 Other (Specify)		iodate of disposition atory or other place) Hi ial Garden			CATION — City o Hampt	on, Virginia		
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE			E AND ADDRESS OF FAC	10/28/95.				
N N N N N N N N N N N N N N N N N N N	Marles C. De	ggz fr.	4906	Iverson P	House o	of Diggs	Mortuary		
100	23. PART I. Entar the diseases, or compile						Approximata		
	ahock, or heert fellure. List on IMMEDIATE CAUSE (Final	nly one ceuse on each line.					Onsat and Death		
	disease or condition resulting in death) a. Head and Neck Injuries OUE TO (OR AS A CONSEQUENCE OF):								
5	OUE TO (OR AS A CONSEQUENCE OF):								
CERTIFICATION	Sequentielly list conditions, If any, leading to immediate								
CAT	cause. Enter UNDERLYING CAUSE (Disease or injury								
	that initiated eventa resulting in death) LAST	OUE TO (OR AS A CONSECU	JENCE OF):						
CER .	d						1		
AL	PART II. Other aignificent conditions cont	tributing to death but not re-	suiting in the under	ying ceuse given in	Part I. 24s. WAS AN PERFOR	AUTOPSY RMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO		
: MEDIC					1 YES 2	MO	OF DEATH?		
WE S	DID TOBACCO USE CONTRIBUT	TE TO CALISE OF DEAT	H VEC [] NO	M UNICEDTAIN			1 YES 2 NO		
IAN	25. WAS CASE REFERRED TO MEDICAL		OF OEATH (Check only		101				
PHYSICIAN:		SPITAL: npatient 2 ER/Outpatient 3	DOA 4 Nursing	Home 5 - Rasidence	8 X Other (Specify)	ON INT	ERSTATE		
PH.	27. MANNER OF DEATH 2	(Month, Day, Year)	286. TIME OF 28c	INJURY AT WORK?	28d. OESCRIBE HOW	NJURY OCCURE	0		
B A	2 Accident Investigation	10/22/95 28s. PLACE OF INJURY - At hom	550A" 1	YES 2 NO	moter wehi	-10	10 4 11 11		
TED TED	3 Suicide 8 Could not be 4 Homicide detarmined	building, atc. (Specify)	stree		281. LOCATION (Street City or Town, State)	Rt 495	near Rt 414		
	29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To	o the beat of my knowledge, dear	th occurred at the time.	data and place, and due		0	mov		
D BE COMPLETED	0001	ha basis of axemination and/or in					ree(s) and manner as stated.		
BE	29b. SIGNATURE AND TITLE OF CERTIFIER	00 1		29c. LICENSE NUM	MBER	29d. DATE SIG	NEO (Month, Day, Year)		
2	30. NAME AND ADDRESS OF PERSON WHO COMP	PLETED CAUSE OF DEATH (ITEM	27) (Type Print)	O.C.M.	E.	ОСТОВ	ER 23.1995		
	DENNIS CHUTE			treet, Ba	altimore	Mary	land 21201		
	31. DATE FILED (Month, Day, Year) 31. DATE FILED (Month, Day, Year) 31. DATE FILED (Month, Day, Year) 31. DATE FILED (Month, Day, Year) 31. DATE FILED (Month, Day, Year) 31. DATE FILED (Month, Day, Year) 31. DATE FILED (Month, Day, Year) 31. DATE FILED (Month, Day, Year) 31. DATE FILED (Month, Day, Year) 31. DATE FILED (Month, Day, Year) 31. DATE FILED (Month, Day, Year) 31. DATE FILED (Month, Day, Year) 31. DATE FILED (Month, Day, Year) 32. DATE FILED (Month, Day, Year) 32. DATE FILED (Month, Day, Year) 33. DA	12 AEGISTRAR'S SIGNATURA	lath						
							DHMH-16 Rev 1/89		

Service I seems the

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPART	MENT OF H	EALTH AND DEATH	MENTAL HYGIEN				
	1. DECEDENT'S NAME (First, Middle, Last)	C	ontre			2. DATE OF DEATH	W. 1905	3. TIME OF DEATH		
	4. SOCIAL SECURITY NUMBER 578-64-0273 98. FACILITY NAME (If not institution, give s	1 → M 2 □ F 46	YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) NOV . 19	1948 WAS	SHINGTON, D.C.		
TOR	SOUTHERN MARYLANI RESIDENCE OF DECEDENT			CLINTON	R LOCATION OF D	EATH	PRINCE			
DIRECTOR	D · C · 106. COUNT	y N/A		TOWN OR LOCAT	ION			10d. INSIDE CITY LIMITS? 1 1 YES 2 NO		
FUNERAL	138 IVANHOE STREI	ET,S.W.		1	ZIP CODE		U.S.A.	WHAT COUNTRY?		
В	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 1 YES IF YES, GIVE WAR OR DAT	2 NO	If yes, spi		NIC ORIGIN? (Specify Yes an, Puerto Ricen, etc.) fy:	se or No— 14. RACE — American Indian, Bleck, White, atc. Specify: BLACK			
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	CATION completed) Coffege (1-4 or 5+) 2	16a. DECEDENT'S U (Give kind of we life. Do NOT use LABORE	ork done during mo. retired.)	N at of working		SINESS/INDUSTRY			
BE CON	17. FATHER'S NAME (First, Middle, Last) JOHN CONTEE SR.		AME (First, Middle, Maiden CONTEE	Surname)						
101	198. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) GLORIA CONTEE 138 IVANHOE STREET, S.W. WASH, D.C. 20032									
	20a. METHOD OF DISPOSITION 1 XI Burial 2 Cremation 3 Rem 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE (I)	oval from State	ANTICO N	ATTONAL	NO	V 2/95 TRI	ANGLE, VII			
	· nulf.	Bacon	276	W.H. I	ATH STR	NERAL HOME	ASH D C	20010		
TION	23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) Due TO (or as a consequence or) Due TO (or as a consequence or): Due TO (or as a consequence or):									
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST	DUE TO (OR AS A C	CONSEQUENCE OF):	:						
AL	PART II. Other algnificent condition	a contributing to death but	t not resulting in	the underlying	cause given in	Part i. 24a. WAS AN PERFOR	IMED?	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
PHYSICIAN: MEDIC	DID TOBACCO USE CONT		DEATH YES		UNCERTAI	NE		1 YES 2 NO		
SIC	1 TES 2 NO	HOSPITAL: 1 Inpatient 2 ER/Outpat		OTHER:	5 - Residence	8 Other (Specify)				
ВУ РН	27. MANNER OF DEATH 1 Metural 8 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME INJU	M 1 Y	IRY AT RK? ES 2 NO	28d. DESCRIBE HOW II	NJURY OCCURED			
	3 Suicide 8 Could not be determined	28a. PLACE OF INJURY – building, etc. (Specify	- At home, ferm, str	reet, factory, office		281. LOCATION (Street a City or Town, State)	and Number or Rural I	Route Number,		
COMPLET		CIAN: To the best of my knowled R: On the basis of examination a) and manner as stated,		
TO BE C	29b. SIGNATURE AND TITLE OF CERTIFIES 30. NAME AND ADDRESS OF PERSON WH	idinguy m	W (ITEM 27) (5mg 6	Perfect)	29c. LICENSE NUI	MBER 30	29d, DATE SIGNED	(Month, Day, Year) 126,1995		
	NOV 1995 J	19112 MD.	5009 P	ryhum	Cr-Cp	Sn. M.	7 207	48		

TO THE HIDPOING DAYSICIAN: The law requires that the death certificate be executed with.

TO THE HIMPOING DAYSICIAN: The law requires that the death certificate be executed with.

TO THE HIMPOING STATE THIS certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be defacted for use as the burial-transit permit. Pages 1, 2, 3 should be made with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

MPORTANT II liam 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be nettified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO.

	1. DECEDENT'S NAME (First	Middle (est)				IOAII	- 01	DLA		HEG. NO			
1.0			n Cunning	1						2. DATE OF DEATH MONTH D	95	YEAR	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER							_			995		3:10 PM M
- 8	The state of the s	100	5. SEX	6. AGE (In yrs. la:		IF UNDER	DAYB	IF UNDER	MIN.	7. DATE OF BIRTH (Month, Day, Year)		Countr	PLACE (State or Foreign
1 1	236 18 7142		1 ★ MI 2 □ F	73	YRS.		- OALIS	noons	win.	Nov. 1 19:	21	Wes	t Virginia
L	9e. FACILITY NAME (If not in	etitution, give a	itreet end number)			9b. CITY	, TOWN	OR LOCATI	ON OF DE	ATH	9c. CO	UNTY OF D	EATH
5	Washington	Advent	tist Hosp	ital		Takoma Park					Montgomery		
5	RESIDENCE OF DEC	EDENT										1080111	.02)
DIRECTOR	10a. STATE	10b. COUNT			10c. CIT	Y, TOWN	OR LOCAT	TION					10d. INSIDE CITY LIMITS?
	Maryland	Princ	e George	's_	Ne	w Ca	rrol	llton					13€XYES 2 NO
₹	10e. STREET AND NUMBER						10	. ZIP COD	E		10g. CI	FIZEN OF W	/HAT COUNTRY?
FUNERAL	8315 Stanw	ood St	reet					2	0784		l t	Inite	d States
3	11. MARITAL STATUS			T EVER IN U.S. AF		13.	WAS DEC			IIC ORIGIN? (Specify Yes			— American Indian, , White, atc.
	1 Never Merried 2 🗵		FORCES? 1	MAR OR DATES	NO		If yes, sp	ecify Cube	n, Mexica	n, Puerto Rican, etc.)		Black	
WWII Wildows 4 Divorced								White					
8	15. DEC	EDENT'S EDU	CATION		CEDENT'S					16b, KIND OF BUS	BINESS/IN	DUSTRY	
(Specify only highest grade completed) Elementary/3econdary (0-12) College (1-4 or 5+) 10 Carpenter Union 17. FATHER'S NAME (First, Middle, Last)													
8	17. FATHER'S NAME (First, M	iddle, Last)			Perre			18 MOT	HER'S NA	ME (First, Middle, Meiden			
0	John C. Cu	nninah	2m					1					
H	19e. INFORMANT'S NAME (alli	10	- MAII INC	ADDRESS	D / (Dens et a			. Wininger			
임	Section 1997	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	da alaam	1."									
- 1	Mildred L		Ingnam						reet	New Carr			
	h Burlel 2 - Crematic	n 3 🗆 Rem	oval from State	cemetery, cre	matony or o	ther pleast						- City or To	
	4 Donation 5 D Other			_ Laken	nont					10/20/95	Dav	idson	nville Md.
1	21. SIGNATURE OF FUNERA	L SERVICE LIC	ENSEE)			ND ADDRE		ns Funeral	11	D	Α
	Kolen	7 6	1711	may t	2000					is Rd. Bov			
	23. PART I. Enter the di	seasee, or	complications the	t coused the de	eth. Do r	not enter	the mo	de of dvi	apor	IS RG. BOV	vie r	id. Z	Approximete
	anock, or n	eart fallure.	List only one cau	se on each fine).		1		mg, addi	r wa cardioc or reapi	ratory at	rest,	interval Between
	iMMEDIATE CAUSE (Fir disease or condition	ial	11. 0	7.8	6	1			1				Opset and Deeth
	resulting in death) - a. INEQSITATE LUCY CAUCET										GEGIV		
1 1	DUE TO (OR AS A CONSEQUENCE OF):												
S S	Sequentially list conditi	one.	b					V					
E	if any, leading to imme- cause. Enter UNDERLY		DOE 10	(OR AS A CONSE	DUENCE OF	r):							
일	CAUSE (Diseese or inju		e. DUE TO	(OR AS A CONSE	NIENOE O								
Ē	that initiated events resulting in deeth) LAS	,	DOE 10	(OH AS A CONSE	JUENCE OF	r):							1
CERTIFICATION	,		d										
٦	PART II. Other aignifice	nt condition	a contributing to	deeth but not r	esulting	In the un	deriyind	Ceuee C	iven in	Part I. 24a, WAS AN	AUTOPSY	24h.	WERE AUTOPSY FINDINGS
MEDICAL									,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	PERFOR			AMAILABLE PRIOR TO COMPLETION OF CAUSE
9										1 YES 2	NO		OF DEATH?
	DID TOPACCO ::	CE COLE	DIDLITE TO CA	LICE OF DE			-	1 400 0 0					1 WES 2 NO
PHYSICIAN:	DID TOBACCO U		KIBUIE IO CA			S XI		JUNC	ERTAIN	101			
5	25. WAS CASE REFERRED TO EXAMINER?	MEDICAL	HOBPITAL:	26. PLAC	E OF DEAT	OTHER							
YSI	1 TES 2 5440			ER/Outpetient 3	□ DOA			e 5 □ Re	sidence	6 Cher (Specify)			
E	27. MANNER OF DEATH		28s. DATE OF (Month, D		26b. TIM	E OF URY	29c. INJ	URY AT		28d. DESCRIBE HOW II	NJURY OC	CURED	
BY		Pending Investigation	ACCES (40.2)	Sections.		м		es at	NO				
	3 🗆 5	Could not be	20s PLACE O	F INJURY — At he etc. (Specify)	me, farm, s	street, fact	ory, office			26f. LOCATION (Street a	nd Numbe	r or Rural Ar	oute Number,
III III		Setermined	1	eca. (opening)						City or Town, State)			
۳۱	28s. CERTIFIER CONT	evine out	Cum de	and beautiful at a set					_	An II	50.00		
COMPLET		CAL EXAMINE								to the cause(a) end man			207.000.000.000
8	11///	1/	1			, III MIY O	риноп, б	watti occur	ed at the t	time, date end place, en	due to t	ne ceuse(e)	end manner se stated.
BE	THE RIGHATURE AND TITLE	OF CENTIFIES	maras	Max				29c. LICE	NSE NUM	BER	29d. DAT	E, SIONED	(Month, Pay, Year)
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- 1	M. NAME MID ADDRESS OF	PERSON WH	D COMPLETED CAU	BE OF DEATH (ITE	# 27) (Type,		_			\	-	11	,
	litomAS t	1. DE	NSNG	EQ 7	1523	5 (2100	owa	19-(1	Cla-Dr.	(91)	seuls	K (US AND The
1	UCT 25 199	(bar)	3 PEGISTRA	R'S SIGNATURE					1		-		
	001 Pa 122	0											1

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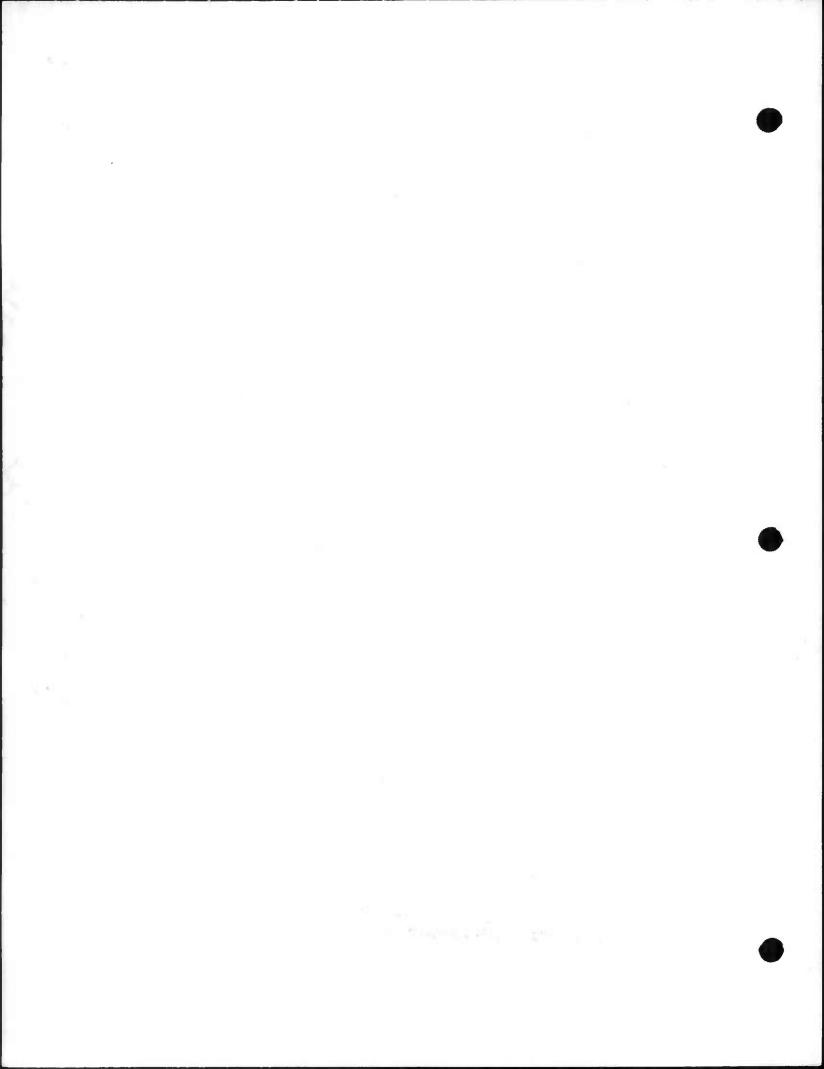
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DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

			95 3	339
FOR STATE REGISTRAR	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND I			
DECEDENT'S HAME (First, Middle, Last)		2. DATE OF DEATH MONTH DAY	YEAR	3. TIME C

. 0	1. DECEDENT'S HAME (First, Middle, Last)								2. DATE OF MONTH	DEATH		YEAR	3. TIME OF DEATH
	Thomas Walter	Dormand	d, Jr.						Oct.	30,			12:25 p. "
li	4. SOCIAL SECURITY NUMBER		6. AGE (In yrs. In	st birthday)	IF UNDER	t YEAR	IF UNDER	24 HRS.	7. DATE OF I	MATH	13		LACE (State or Foreign
1 3	077-09-2427	1 XM 2 F	89	YRS.	MONTHS	DAYB	HOURS	MIN.	(Month, De	sr. Manr)	10	Country)	
1	077-03-2427		09						Dec.	1/,	19	J5 E1	ngland
~	9a. FACILITY NAME (If not institution, give st	Mariand number) Ma	allard	Bay	9b. CITY,	TOWN 0	R LOCATIO	ON OF DE	ATH		9c. COU!	NTY OF DEA	ATH
Ö	Nursing & Rehal	oilitati	on Ce	nter		Ca	mbr	ida				No mal	hester
5							UIII / I	Lugi				JOICE	lester
#	10a. STATE 10b. COUNTY			10c. CITY	, TOWN O	R LOCAT	ЮН						IOd. IHSIDE CITY
ā	Maryland Don	chester				Can	bri	dae					YES 2 X NO
7	10e. STREET AND HUMBER	-				_	ZIP CODE				10a CITI		AT COUNTRY?
FUNERAL DIRECTOR	10 Nanticoke Ro					1 1	30 37.53				log. Gir		
岁	11. MARITAL STATUS				-			1613				U.S	5.A.
2	11. MARITAL STATUS 1 Never Married 2 Merried	12. WAS DECEDENT FDRCES? 1	YES 2 12	ND	13. V	MAS DEC	ENDEHT O	F HISPAH	IC ORIGIN? (S	pecify Yes	or Ho—	14. RACE -	- American Indian, White, atc.
ВУ	3 X Widowed 4 Divorced	IF YES, GIVE W	R OR DATES				YES 2 XNO Specify:			1, 410.7	- 1	Specify:	
	S.A										I	-	White
COMPLETED	15. DECEDEHT'S EDUC (Specify only highest grade	CATION COMO(ntmcf)	16a. Di	CEDENT'S L	JSUAL OC	CUPATIO	N ef weeds		16b. KJH	D OF BUS	IHESS/IHD		
Щ	(Specify only highest grade completed) (Give kind of work done during most of working life. Do NOT use retired.)												
립	9		Own	ner/C	ont	rac	tor		Ru	1141	na (onel	ruction
중	17. FATHER'S NAME (First, Middle, Last)		, , , , , ,						ME (First, Middl			0113	Luction
		D	0										
H	Thomas Walter	Dormand							inne I				
0	19a. INFORMANT'S NAME (Type/Print)		19	b. MAILING	ADDRESS	(Street a	nd Number	or Rural R	loute Number, (Ity or Town	, State, Zip	Code)	
-	G. Elaine Hicks	3	5	126	Paw	Par	W Ro	ad,	Camb	rido	ie,	MD.	21613
	20a. METHOD OF DISPOSITION		20b. PLACE						DATE			City or Town	
ŀ	1 X Buriel 2 Cremation 3 Ramo	oval from State	cemetery, cre	matory or oth	ner plece)				1-1				
	21. SIGNATURE OF PUNETIAL SERVICE LIC	ENSEE A	DOLCI	reste			D ADDRES			Ca	mpr 1	lage,	MD.
	.4	4									1		
	MON DOON STAIN	nd-181	m 01	12	13U	Q II	n-Bi	COMM	, Car	une	rai	HOME	P.A.
	23 PART & Enter the diseases, or c	omplications that	coused the de	eath. Do no	ot enter	the mor	de of dyl	ng auch	an cardiac	or resoir	etopy are	MD.	21613 Approximate
	ahock, or heart fellure. I	List only one caus	e on each ilne				-c c. c,.		. 44 0410100	от тоари	atory arr	out,	interval Between
ı	IMMEDIATE CAUSE (Final disease or condition	1	- 0										Onset and Death
l l	resulting in death)	HATC	=R10S	CLGA	OTIC		AR	016	VASCL	LL AI	- Du	SGASG	Science
	DUE TO (OR AS A CONSEDUENCE OF):												
z													1000
0	Sequentially list conditions, If any, leading to immediate DUE TO (DR AS A COHSEQUENCE DF):												
= 11	cause. Enter UNDERLYING												
¥	cause. Enter UNDERLYING												
FICATI	CAUSE (Disease or injury	those (Disease or Injury that Inflited events DUE TO (DR AS A CONSEQUENCE OF):											į l
TIFICATI		DUE TO (resulting in death) LAST										
CERTIFICATI	CAUSE (Disease or injury that initieted events	DUE TO (
L CERTIFICATION	CAUSE (Disease or injury that initiated events resulting in death) LAST	1	leeth but not	eeuiting Ir	the unc	derivina	cause o	iven in I	Pert i. 24a	. WAS AN A	UTOPSY	24b W	/FRF ALTTOPSY FINDINGS
	CAUSE (Disease or injury that initieted events	1	leeth but not	recuiting in	the unc	derfying	cause g	lven in i	Pert i. 24s	. WAS AN A		A	VERE AUTOPSY FINDINGS WAILABLE PRIOR TO
	CAUSE (Disease or injury that initiated events resulting in death) LAST	1	leeth but not	recuiting in	the unc	derlying	cause g	lven in I			AED?	A	
	CAUSE (Disease or injury that initiated events resulting in death) LAST	1	leeth but not	recuiting Ir	the unc	derlying	cause g	lven in i		PERFORM	AED?	C	MARLABLE PRIOR TO OMPLETION OF CAUSE
: MEDICAL	CAUSE (Disease or injury that initiated events resulting in death) LAST	e contributing to d							10	PERFORM	AED?	C	MARLABLE PRIOR TO OMPLETION OF CAUSE OF DEATH?
: MEDICAL	CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant conditions DID TOBACCO USE CONTR	e contributing to d	JSE OF DEA		S 🗆 N	10 🗆			10	PERFORM	AED?	C	MARLABLE PRIOR TO OMPLETION OF CAUSE OF DEATH?
: MEDICAL	CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant conditions DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	e contributing to d	JSE OF DEA	TH YES	S N	O O	UNC	ERTAIN	_ 10	PERFORM	AED?	C	MARLABLE PRIOR TO OMPLETION OF CAUSE OF DEATH?
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BY PHYSICIAN: MEDICAL	CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant conditions DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1	RIBUTE TO CAL HOSPITAL: 1 Inpetient 2 26a. DATE DF I (Month, Da) 28a. PLACE DF building, a	JSE OF DEA 26. PLAN 27. PLAN 28. PLAN 18. JURY 28. Veer) 18. JURY — Al hoto. (Specify) 19. knowledge, de	TH YESE DF DEATH	S N I (Check o OTHER 4 M Nural OF IRY M I ot the lin	IO IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII	UNC 5	ERTAIN sidence NO and due	6 Other (Sp. 28d, DESCRIE) 261, LOCATIO City or To	PERFORM YES 2 ecity) BE HOW IN N (Street arwn, State)	JURY OCC	CO 0 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	MALABLE PRIOR TO OMPLETION OF CAUSE F DEATH? YES 2 ND
COMPLETED BY PHYSICIAN: MEDICAL	CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant conditions DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES NO 27. MANNER DF DEATH 1 Netural 5 Pending Investigation 2 Accident Investigation 3 Suicide 6 Could not be detarmined 29a. CERTIFIER (Check only)	RIBUTE TO CAU HOSPITAL: 1 Inpatient 2 26a. PLACE DF building, a	JSE OF DEA 26. PLAN 27. PLAN 28. PLAN 18. JURY 28. Veer) 18. JURY — Al hoto. (Specify) 19. knowledge, de	TH YESE DF DEATH	S N I (Check o OTHER 4 M Nural OF IRY M I ot the lin	IO IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII	UNC 5 Re JRY AT RK7 ES 2 and plece, path occurrent	ERTAIN sidence NO and due	1 Control of the cause of the c	PERFORM YES 2 ecity) BE HOW IN N (Street arwn, State)	JURY OCC	O 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	MALABLE PRIOR TO OMPLETION OF CAUSE F DEATH? YES 2 ND No Number, Ind manner as stated.
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BE COMPLETED BY PHYSICIAN: MEDICAL	CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant conditions DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES NO 27. MANNER DF DEATH 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be detarmined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER 29b. SIGNATURE AHD TITLE OF CERTIFIER 30. NAME AHD ADDRESS OF PERSON WHO	RIBUTE TO CAL HOSPITAL: 1 Inpetient 2 26a. DATE DF I (Month, De) 28a. PLACE DF building, a CIAN: To like best of an	26. PLAGE 26. PL	TH YESE OF DEATH DOA 28b. TIME INJU me, larm, st ath occurred investigation 4 27) (Type, i	S N N (Check o OTHER 4 M Nurse) OF NY M reat, lacto	nly one) :: ing Home 28c. INJL WOO 1 Ury, offica	UNC 5 GRa JRY AT RK7 ES 2 GRA and placa, anth occurr 29c. LICE	ERTAIN sidence No and due and st like is	261. LOCATION City or To	PERFORM YES 2 ecity) SE HOW IN N (Street ar wm, State)	JURY OCC JURY OCC Ind Number Index so state Jury Occ	or Rural Roules of Cause(s) as a cause(s) as	MALABLE PRIOR TO OMPLETION OF CAUSE F DEATH? YES 2 ND No Number, Ind manner as stated. Sorth, Day, Year)
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TO THE HOSPITAL OR ATTEND TO THE FUNERAL DIRECTOR: / be filed within 72 hours after or IMPORTANT: If item 28 is

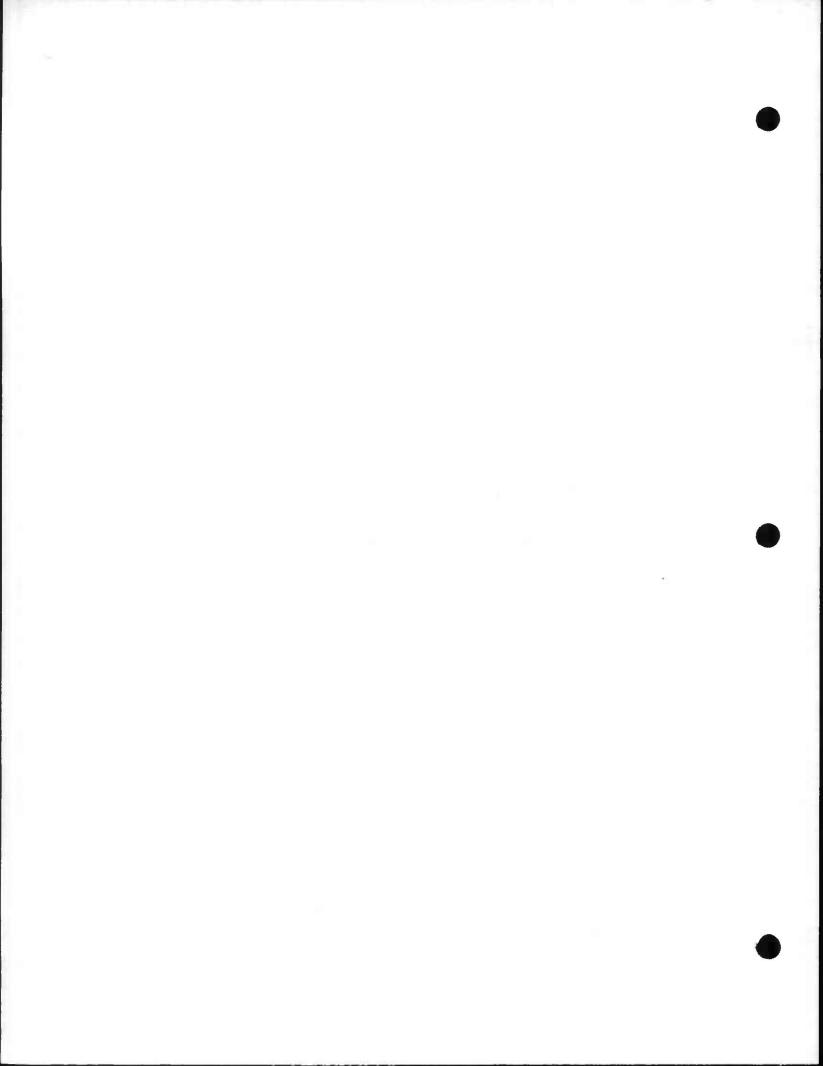
	ECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should		
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JUNG PRINCIPALY THE LAW REQUIRES THAT THE UPGALL CELUISATE DE EXECUTED WITH THOURS ARE DEATH. PAGE & MAY DE RELAMED BY THE HOSPITAL OF ARE	Wer !	eath	mar
END	DR: A	fler d	1.28 is marked or Harn 22 shows any injury or other transmits awant the marked averaging much has acately at account
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BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR 1 . STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CERTIF	ICATE (OF DEATH	REG. NO	O.		
0	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3	TIME OF DEATH
0		Casper Garr	ett Dunb	ar		October	25	45	2310 M
- 33			(In yrs. last birthday)	IF UNDER t YE	AR IF UNDER 24 HRS.	7. DATE OF BIRTH	7/2	6. BIRTHPL	ACE (State or Foreign
	212-18-4021	X M 2 □ F	82 YRS.	MONTHS DA	YS HOURS MIN.	Feb. 24,	1013	Country)	land
- 1	Se. FACILITY NAME (If not institution, give stree	t end number)		9b. CITY, TO	WN OR LOCATION OF E			THE T Y	
E	Union Hospital of	Cecil Coun	tv	Elkt	On		Cec		
K	RESIDENCE OF DECEDENT	TOTAL TOTAL		Direc	OII .		1000.	1.1	
DIRECTOR	10e. STATE 10b. COUNTY		10c, CIT	Y, TOWN OR L	DCATION			10	Dd. INSIDE CITY
	Maryland Cecil		E1	kton				1	LIMITS?
A	10e. STREET AND NUMBER				101. ZIP CODE		10g. CITI		AT COUNTRY?
E	313 Delaware Aven	ue			21921		U.S	S.A.	
FUNERAL	11. MARITAL STATUS	2. WAS DECEOENT EVER II		13. WAS	DECENDENT OF HISPA	INIC ORIGIN? (Specify Y	s or No	14. RACE -	- American Indian,
7	1 Never Married 2 Married	FORCES? 1 YES	2 NO ATES	If yes	i, specify Cuben, Mexic YES 2 X NO Speci	an, Puerto Rican, etc.)	200,000	Black, V	White, atc.
BY	3 Widowed 4 Divorced	World War		'-	TEO L MO CODE	···	_	Specify:	White
COMPLETED	15. DECEDENT'S EDUCAT (Specify only highest grade cor	TION	16a. DECEDENT'S			16b. KIND OF B	JSINESS/IND	USTRY	
<u>u</u>	THE PROPERTY OF THE PROPERTY O	College (1-4 or 5+)	ille. Do NOT us	e retired.)	g most of working				
4	10		Painte	r		Painti	ng, se	elf-er	mployed
Ö	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S N.	AME (First, Middle, Maide			
BE	Evans L. Du	unbar				Dorothy	Garret	tt	
8	19e. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Str	set end Number or Rural	Route Number, City or To	vn, Stete, Zip	Code)	
5	Edith P. Miller					- Elkton,		1921	
	20a. METHOD OF DISPOSITION		PLACE AND DATE		N (Nama of	1 0ATB 0 20c. L	OCATION (City or Town	State
	1 X Suriel 2 Cremation 3 Remova 4 Donation 6 Other (Specify)		nion Cem	etery		10-30 11995 Un			
	21. SIGNATURE OF FUNERAL SERVICE LICEN			22. NAM	E ANO ADDRESS OF F	CILITY			2110
	• 1	1111				r Funerals	-		
	Donald	J. Heeks				on St., El			1921-5521
- 1	23. PART I. Enter the diseases, or com shock, or heart failure. Lie	nplications that caused it only one cause on a	I the death. Do r ach line.	ot anter the	mode of dylng, suc	ch as cardiac or resp	iratory arm	eat,	Approximata Interval Between
	IMMEDIATE CAUSE (Final								Onset and Death
	disease or condition a. Browdth Predmiller Browdth Predmiller DUE TO (OR AS A CONSEQUENCE OF):								
	DUE TO (OR AS A CONSEQUENCE OF):								
Z	Sequentially list conditions, list any leading to immediate b. CON GRATNE ITEMPT FMLURE DUE TO (OR AS A CONSEQUÊNCE OF):								1 year
Ĕ	if any, leading to immediate	DUE TO (OR AS A	CONSEQUENCE OF	700					
3	CAUSE (Disease or Injury	ter UNDERLYING Isease or Injury Due to (OR AS A CONSEQUENCE OF):							
E	that initiated events resulting in death) LAST				4- 0 - (0		A . e . i		2.40
CERTIFICATION	d	MILELLE	SCIERO	1100	DUNON	scular	MISE	435	3 Chts
	PART II. Other algnificant conditions of	ontributing to death b	ut not reaulting i	n the Undari	ying cause given in	Part I. 24a. WAS A		24b. WI	ERE AUTOPSY FINDINGS
EDICAL							RMED?		MILABLE PRIOR TO MPLETION OF CAUSE
						1 🗆 YES	2 (PNO		DEATH?
Σ.	DID TOBACCO USE CONTRIB	BLITE TO CALISE O	E DEATH VE	с П ио	UNCERTAI			1	YES 2 NO
A I	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEAT		*				
PHYSICIAN:	EXAMINER?	OSPITAL:		OTHER:		1 - 1 - 2 - 2 - 2 111			
¥ I	27. MANNER OF DEATH	Inpatient 2 ER/Outp	26b, TIM		Home 5 Residence				
	1 Natural 5 Pending	(Month, Day, Year)		URY	WORK?	28d. DESCRIBE HOW	INJUHY OCC	UHED	
B	2 Accident Investigation 3 Suicide 6 Could get be	28e. PLACE OF INJURY	- At home term			201 1 201 101 10		10.00	
8	4 Homicide 6 Could not be determined	building, atc. (Spec	ffy)	treet, ractory, t	этсе	281. LOCATION (Street City or Town, State	end Number ()	or Rural Flout	w Number,
	290. CERTIFIER								
를	(Check only CERTIFYING PHYSICIAL	N: To the best of my knowl							
COMPLET	2 MEOICAL EXAMINER: C	on the beele of examination	end/or investigatio	n, in my opinio	n, death occured at the	time, date end place, e	nd due to the	cause(e) en	nd manner ee stated.
BE	29b. SIGNATURE AND TITLE OF CERTIFIER	- 2			29c. LICENSE NU	MBER	29d. DATE	SIGNED (M	onth, Day, Year)
TO B	Juliment, les	Jul 1			10078	663	10	186	195
F	30 NAME AND ADDRESS OF PERSON WHO C	OMPLETED CAUSE OF DEA	ATH (ITEM 27) (Type,	Printy					21921
Ì	Rolando IVAic	RA M.D	. 118 1	Joeth	St Suite	24 1-	IK+	on/	mi
	31. DATE FILED (Month Day, Year)	32. REGISTRAD'S SIGN	ATURE _	- 10///	2011		/	- 101	
	OCT 2 7 1995	Jalin dawde	on-transfall						
									DHMH-16 Rev 1/89



TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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	FOR 1 - STATE REGISTRAR	STATE OF	MARYLAND	DEPAR	RTMENT	OF I	HEALTH	AND	MENTA					
	1. DECEDENT'S NAME (First, Middle, Last)		CERTIFICATE OF DEATH					REG. NO. 2. DATE OF DEATH MONTH DAY YEAR				3. TIME OF DEAT	TH	
	Jeanne C. II 4. SOCIAL SECURITY NUMBER S. SEX 6. AGE (In yr.			ortwegt s. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.				24 HRS.	October 26, 1995				2022 PLACE (State or Fo	ne contrar
	141-28-8120	1 🗆 M 2 💢 F	72	YRS.	MONTHS	DAYS	HOURS	MIN.	(Mont	, Day, Year)	1022	Countr	Netherl	
COMPLETED BY FUNERAL DIRECTOR	9e. FACILITY NAME (If not institution, give street and number)			96. CITY, TOWN OR LOCATION OF			ON OF DI		21,		JATY OF D		ands	
	1460 Appleton Road Elkton Cecil													
	10e. STATE 10b. COUNTY				10c. CITY, TOWN OR LOCATION									,
	Maryland Cecil				E1kton								1 YES 2 X	NO
	10. STREET AND NUMBER				10f. ZIP CODE				10g. CITIZEN OF				HAT COUNTRY?	
	1460 Appleton Road				21921				U.S.			S.A.		
	11. MARITAL STATUS 1 Never Merried 2 X Merried 3 Widowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES							ean, Puerto Rican, atc.) Blo			14. RACE Black Specie	- American India, White, etc.	en,	
	15. DECEDENT'S EDU (Specify only highest grade	CATION COMPOSITE OF		ECEDENT'S					166	KIND OF B	JSINESS/IN	DUSTRY		
	Elementary/Secondary (0-12) College (1-4 or 5+)				(Give kind of work done during most of working life. Do NOT use retired.) Homemaker				None					
	17. FATHER'S NAME (First, Middle, Last)						18. MOTI	HER'S NA		Middle, Meide	n Sumeme)			
BE C	Arie Kell	lenbach							Jea	nne C	. Pie	erot		
10 B	19e. INFORMANT'S NAME (Type/Print)									per, City or To		ip Code)		
-	Johan Dortwegt 1460 Appleton Road - Elkton, MD 21921													
	20e. METHOD OF DISPOSITION 1 Duriel 2 X Cremetton 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of cemetary, crematory or other place) 20c. LOCATION — City or Town, State													
	1 Burlet 2 (A Cremetion 3 Removal from State Cameton, crematory or other place) LU-Z/ R.A. Ferris & Company 1995 West Chester, PA 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACULTY													
3	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Hicks Home for Funerals, P.A. 103 W. Stockton St., Elkton, MD 21921-5521									521				
	23. PART I. Enter the diseases, or complications that caused the death, Do not enter the mode of dying, such as cardiac or respiratory arrest.									ata				
PHYSICIAN: MEDICAL CERTIFICATION	shock, or heert fellure. List only one cause on each il IMMEDIATE CAUSE (Finel disease or condition resulting in death) a. Pancreate				T Canon									Death
	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): d.													
	Squeen (all Coremona of vocal and 1 yes 2 1/40								WERE AUTOPSY FI AMAILABLE PRIOR COMPLETION OF CO OF DEATH?	TO				
~ :	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO IN									1 (1 123 2 (1)	NO			
NA!	25. WAS CASE REFERRED TO MEDICAL. 28. PLACE OF DEATH (Check only one)													
SIC	EXAMINER? 1 YES 2 NO													
H	27. MANNER OF DEATH	28e. DATE OF INJURY (Month Day Year) 28b. TIME OF 28c. INJURY AT (Month Day Year)							28d. DEŞCRIBE HOW INJURY OCCURED					
ВУ	1 Natural 5 Pending M 1 YES 2 NO						NO	281. LOCATION (Street end Number or Rural Route Number, City or Town, State)						
1	3 Suicide 6 Could not be determined 29e. PLACE OF INJURY — At home, Ierm, street, fa building, etc. (Specify)					factory, office								
COMPLETED	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end manner as stated. 2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the lime, date and place, end due to the cause(e) end menner se stated.													
BE C	296. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Day, Year								(Month, Day, Year)					
TO B	DOURN WORKER OF DESCRIPTION DY 373 10/27/45													

27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Netural 1 YES 2 NO 2 Accident 28e. PLACE OF INJURY — At home, Ierm, street, factory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number of Rural Route Number, City or Town, State) 6 Could not be determined 4 Homicide 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end manner as stated. 2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occured at the lime, date and place, and due to the cause(e) and menner or stated. 296. SIGNATURE AND TITLE OF CERTIFIS 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 044373 rentsteel 10 27/45 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Joseph Weidner, M.D. 101 Colonial Way, Suite 1 - Rising Sun, MD 21911 31. DATE FILED (Month, Day, Year)
OCT 2 7 1995 32. REGISTRAR'S SIGNATURE

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlat-transit permit. Pages 1. 2. 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlat, cremation, or removal.

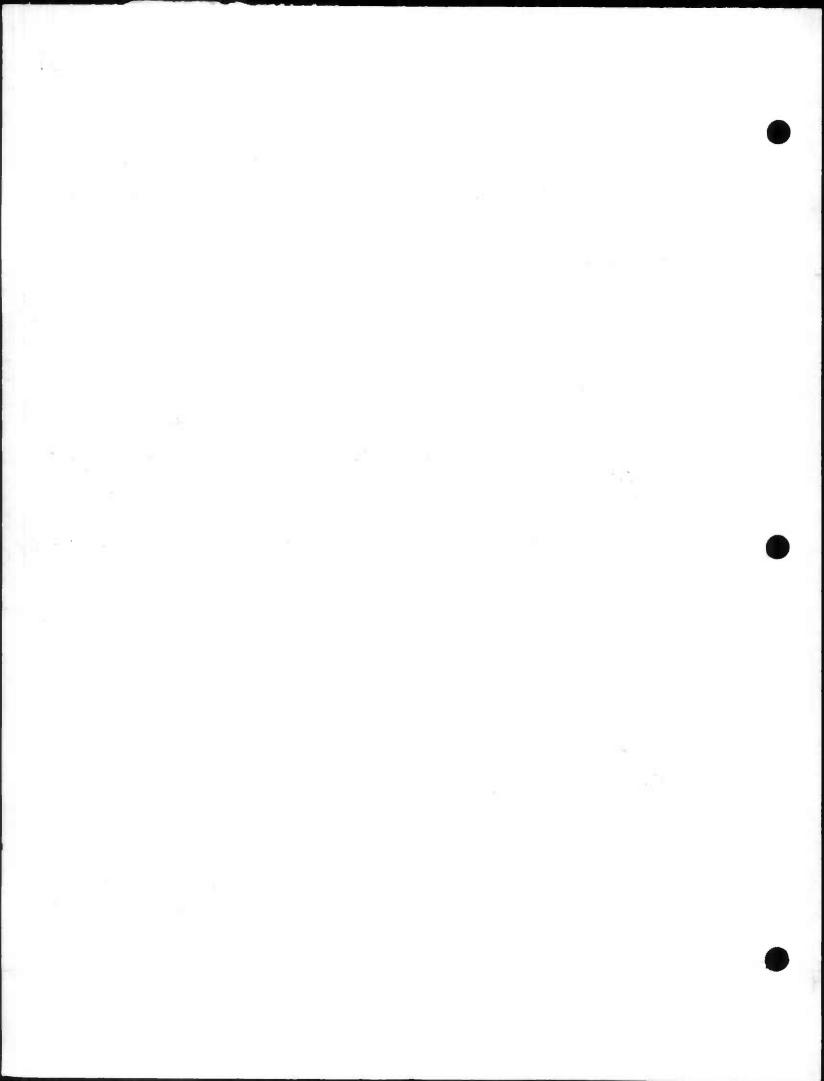
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. *BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	1 - STATE REGISTRAR	OINIE OI MINI	CERTIF	CATE OF		REG. NO.					
	t. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATN		3. TIME OF DEATH				
	JANE	C.	DENNEY			October 2	1995	3:32 A M			
COMPLETED BY FUNERAL DIRECTOR		5. SEX 1 M 2 X F	AGE (In yrs. last birthday) 75 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Aug. 4,1	920 N. BIRT Coun M. a.	NPLACE (State or Foreign aryland			
	Se. FACILITY NAME (If not institution, give street and number) Knollwood Manor Nursing Home 96. COUNTY OF DEATH Millersville Anne Arundel										
	residence of decedent 100. STATE 10b. COUNTY Maryland (toc. CITY	Y, TOWN OR LOCAT		10d, INSIDE CITY						
	100. STREET AND NUMBER 100. STREET AND NUMBER 101. ZIP CODE 102. CITIZEN OF WHAT COUNTRY? 21921 103. CITIZEN OF WHAT COUNTRY? 21921 104. S. A.										
	t1. MARITAL STATUS t Never Merried 2 Merried Widowed 4 Divorced	YER IN U.S. ARMED YES 2 XNO OR DATES	R NO It yes, specify Cuben, Mexicen, Puerto Rican, etc.) Bis								
	15. DECEDENT'S EDUC	15. DECEDENT'S EDUCATION (Specify only highest grade completed)		USUAL OCCUPATION		16b. KIND OF BUS	INESS/INDUSTRY				
	Elementary/Secondary (0-12) College (1-4 or 5+)		Homen	e retired.)		At Home					
	17. FATNER'S NAME (First, Middle, Last) Thomas W. O'Bri					ME (First, Middle, Malden					
H	THOMAS W. U'BEI	len	19h MAILING	ADDRESS (Street of	Mary E. Sturgen RESS (Street end Number or Bural Route Number, City or Town, State, Zip Code)						
2	Scott Agee					en Burni		21061			
	20s. METNOD OF DISPOSITION 1A Burlai 2 Cremetion 3 Removal from State 4 Donetton 5 Other Specify Bethel Cemetery 10/24/95 Chesapeake City, Md.										
	21. SIGNATURE OF UNERAL SERVICE LICE		perior or	22. NAME A	D ADDRESS OF FA	CILITY 25	9 E. Ma	ain St., Md. 21921			
MEDICAL CERTIFICATION	23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death disease or condition resulting in death) Due To (or as a consequence of): Due To (or as a consequence of): Due To (or as a consequence of): Due To (or as a consequence of): Due To (or as a consequence of): Due To (or as a consequence of): Due To (or as a consequence of):										
	PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS										
						PERFORMED? 1 YES 2 NO COMPLETION OF DEATH 1 YES 2 NO PERFORMED?					
	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN										
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: OTHER:										
1YS	1 YES 2 NO	1 Inpatient 2 EF	VOutpetient 3 DOA	4 Nursing Hon	e 5 Residence	8 Other (Specify) 28d. DESCRIBE HOW I	N HIEW COCHEEN				
BY PI	1 Mitural 5 Pending 2 Accident Investigation	(Month, Day,	bar) IN.	M t	YES 2 NO						
8	3 Suicide 6 Could not be determined 28e. PLACE OF INJURY — At home building, atc. (Specify)			street, tactory, offic	•	28t. LOCATION (Street end Number or Rural Route Number, City or Town, Stete)					
COMPLET	29e. CERTIFIER (Check only one) 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end manner as stated. 2 MEDICAL EXAMINER: On the best of exemination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(e) end manner as stated.										
B	296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 10123191										
2	30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATN (ITEM 27) (Typo, Print) SURYAP. MUNDILA MD 203 & Patapsio Ar. Ball 21224										
	31, DATE FILED (Month, Day Year) 32, REGISTRAR'S SIGNATURE										
	OCT 26, 1995 Jul	develor 1	arlath								



HI OF	AT BE	IMPO
IND THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the filed within 72 hours after death with the State Debt. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Hem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
OR ATTENDI	IRECTOR: A	em 28 is
NG PHYSIL	fter this co	marked,
SIAN: The	brtificate hi	or item
law require	as been signed. Of Hea	23 shows
s that the d	ned by the	any injur
eath certifi.	attending partial Hygien.	y, or other
cate be exe	hysician an e prior to b	er trauma
cuted within	d complete	tic event,
in 24 hours	ly filled in ation, or n	the med
s after deat	by the fun smoval.	dical exar
h. Page 6 r	eral director	niner mut
nay be reta	page 5 sl	pt be not
ined by th	hould be di	fled at o
hospital o	stached for	nce.
or attending	use as the	
physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit puber filed within 72 hours after death with the State Dept. or Health and Mental Hygiene prior to burial, cremation, or removal.	
	it permit.	

31. DATE FILEO (Month,

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2 DATE OF OEATH 3. TIME OF DEATH Leto ber harles emers 4. SOCIAL SECURITY NUMBER 7. OATE OF BIRTH (Month, Day, Year, 8. AGE (In vrs. last birthday IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign DAYS 1 X M 2 - F HOURS 095-05-3480 79 Sept. 20. New York Sa. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 3131 Queens Chapel Road Mt. Rainier Prince George's RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Prince George's Mt. Rainier 1 1 YES 2 NO FUNERAL 10e STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 3131 Queens Chapel Road 20712 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ∑ YES 2 NO IF YES, GIVE WAR OR DATES 11 MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. If yes, specify Cuban, Maxican, Puarto Rican, atc.)

1 YES 2 NO Specify: 1 X Never Married 2 Married BY 3 Widowed 4 Divorced White COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specifi Elementary/Secondary (0-12) College (1-4 or 5+) 12 Mail Clerk Government 17, FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) (Unknown) (Unknown) BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING AOORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 6619 Mayfair Drive #201, Falls Church, VA 22042 Beryl Morgan 20a. METHOD OF DISPOSITION
1 Buriel 2 X Cremation 3 Ren 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION - City or Town, Stata Metropolitan Crematory 10/19/95 Alexandria, Virginia 4 Donation 5 Donation Specify) 21. SIGNATURE OF UNERAL BERVICE LICE 22. NAME AND ADDRESS OF FACILITY
Francis Gasch's Sons Funeral Home, P.A. emy 4739 Baltimore Ave., Hyattsville, MD 20781 23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory street, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death IMMEDIATE CAUSE (Final disease or condition Menopeleratie Cardiovas cules direase resulting in death) CERTIFICATION Sequentially list conditions, OUE TO (OR AS A CONSEQUENCE OF) if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Diseese or injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PERFORMED? 1 YES 2 NO 1 | YES 2 | NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO IT UNCERTAIN I PHYSICIAN: 26. PLACE OF OEATH (Check only one, 25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNEB-OF DEATH 28a. OATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d. OESCRIBE HOW INJURY OCCURED 1 - Natural 5 Pending Investigation 1 YES 2 NO BY 2 Accident 26a. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 281, LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be COMPLETED 4 Homicide 29a. CERTIFIER

(Chark with 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, 296. SHAFTURE AND TITLE OF CERTIFIER LICENSE NUMBER 29d_DATE_SIGNED (Month, Day, Year) Jugusto July 45T

OHMH-16 Rev 1/89

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 6876

	REGISTRAR		CE	RTIF	ICATE	OF	DEATH		REG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last)							2. DATE OF	DEATH		III LOCA	3. TIME OF OEATH	
	George E. David							Octob	er 1	Š. 19	995	11:17 A	M
	4. SOCIAL SECURITY NUMBER		AGE (In yrs. last	birthday)	IF UNDER 1 Y	EAR	IF UNDER 24 HRS.	7. DATE OF	BIRTH	,		IPLACE (State or Fore	
	229-28-0721	1 ▼ XM 2 □ F	79	YRS.	MONTHS E	DAYS	HOURS MIN.	May 1		916	Count	nsylvania	
	9a. FACILITY NAME (If not institution, give str	reet and number)			9b. CITY, TO	OWN OF	R LOCATION OF DE	EATH		9c. COI	JNTY OF D	EATH	
DIRECTOR	Suburban Hospital				Beth	esd	a		. —	Mon	tgome	ry Count	у
Ä	10a. STATE 10b. COUNTY			10c. CIT	Y, TOWN OR	LOCATI	ON					10d. INSIDE CITY	
	Maryland Montgo	mery Coun	ty	E	ethes	da						1 TES 2 X N	10
FUNERAL	100. STREET AND NUMBER 4221 East-West Hi	ohway				101.	20814			Uni	ted S	what country?	
Ž	11. MARITAL STATUS	12. WAS DECEDENT E	VER IN U.S. ARI	WED	13, WA	S DECE	ENDENT OF HISPAN	NIC ORIGIN?	Specify Yes		Ameri	Ca E — American Indian	
BY FI	1 Never Married 2 Married 3 Divorced	FORCES? 1X IF YES, GIVE WAR WWII		0	If y	es, spe	Cify Cuban, Mexica	in, Puerto Rici			Spec	k, White, stc.	
	15. DECEDENT'S EDUC	ATION	16a. DEG	CEDENT'S	USUAL OCC	UPATIO	N	16b. K	IND OF BU	SINESS/IN		vnite	
岡	(Specify only highest grade of Elamentary/Secondary (0-12)	College (1-4 or 5+)	iiie.	Do NOT u	work done duri se retired.)	ing mos	it of working						
COMPLET		6	Br	oker				R	eal I	Estat	te		
8	17. FATHER'S NAME (First, Middle, Last)						18. MOTHER'S NA	ME (First, Mid	die, Maiden	Sumame)			
BE	Elias E. David						Freida	Not	Ava:	ilab]	Le		
10	19a. INFORMANT'S NAME (Type/Print)						nd Number of Rural i				,		
٦	Kathryn V. David		4	221	East-	Wes	t Highwa	ay, Be	theso	la, l	Ω 2	0814	
	20a. METHOD OF DISPOSITION 1XXBurlal 2 Cremation 3 Ramo	oval from Stata	20b. PLACE A cometery, cres	matory or o	ther place)			10719				own, State	
	4 Donation 5 Other (Specify)	ENSEE #MOO		Lawr	Ceme		D ADDRESS OF FA	1995	TROM.	Ling	Gree	n, Virgi	nia
	Khunid	ACO	Δ.	^	St	ork	e Funera Box 920,	al Hom		Trees	7 V A		
	23. PART I. Enter the disease, or c	omplications that c	eused the de	eth. Do								Approximat	te
	shock, or heert fellure. I				ory	1	Arcest	4				Interval Bell Onset and	
	DUE TO (OF AS A CONSEODENCE OF): (Chapter MASS) (Chapter MAS												
z l	IMMEDIATE CAUSE (Final disease or condition resulting in death) 8. Cordumlunary Arrest Due to (of As A consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury thet initiated events Due to (or As A consequence of): Due to (or As A consequ												
CERTIFICATION	If any, leading to Immediate cause. Enter UNDERLYING												
5	CAUSE (Disease or Injury that Initiated events Due to (or as a consequence of): Due to (or as a consequence of):												
Ē	thet initiated events reaulting in death) LAST COVUMENCE OF: DUE TO (OR AS A CONSEQUENCE OF): COVUMENCE OF): Prostate											2261	Tes
8	d												
DICAL	PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 248. WAS AN AUTOPSY PERFORMED? 1 YES 2 THO OF DEATH?												
ME													
ž	DID TOBACCO USE CONTR	RIBUTE TO CAU	SE OF DEA	TH Y	ES NO	0 🗆	UNCERTAIL	N□					
<u>¥</u>	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOOMTAL	26. PLAC	E OF DEA	TH (Check onl	y one)							
S	1 TES 2 DIO	HOSPITAL:	R/Outpatient 3	□ DOA	OTHER:	g Home	5 🗆 Residence	8 Other (S	Specify)				
PHYSICIAN:	27. MANNER OF DEATH	28s. DATE OF IN (Month, Day,	JURY Year)	28b. TIN	IE OF 2	Bc. INJU		28d. DESCR	NOH 38IF	NJURY O	CCURED		
BY	1 Naturel 5 Pending 2 Accident Investigation				1000		ES 2 NO						
	3 Suicide 8 Could not be detarmined	28e. PLACE OF I building, ald	NJURY — Al ho c. (Specify)	me, farm,	streal, factory	y, office		28f. LOCAT City or	ION (Street Town, State)	and Numb	er or Rurel	Route Number,	
١٣	29a. CERTIFIER 1 CERTIFYING PHYSIC	CIAN: To the heat of m	v knowledne de	eth occum	ad at the tim	deta	and place, and due	to the course	(a) and ma		etad		
COMPLETE	onel	R: On the basis of axar										s) and manner as sta	rted.
	29b. SIGNATURE AND TITLE OF CENTIFIER												
BE	Repost 1/6	voyel	MO)			29c. LICENSE NUI	27		N	10.1	7-95	
임	30. NAME AND ADDRESS OF PERSON WHO	O COMPLETED CAUSE	OF DEATH (ITE	M 27) (Type	, Print)		1 /			-	-	, , ,	
	11570 old	georg	ekon	n,	Ros	d	Lo	cho	rll	0,1	40	-2085	2
	31. DATE UCT 23 1995	PLAN CURLIN	SIGNATURE	14									

44.1 Let

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH REG. NO 2. DATE OF DEATH DAY 1. DECEDENT'S NAME (First, Middle, Last) 3. TIME OF DEATH OCTOBER 19 1995 11:50 Pm **IERRY** DUNLAP 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH 8, AGE (In yrs. last birthday 8. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR IF UNDER 24 HRS. 1/2 Jan 21 1968 578-82-1817 27 Washington DC Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give stre 9b. CITY, TOWN DR LOCATION OF DEATH 9c. COUNTY OF DEATH FORESTVILLE 4415 RENA ROAD DIRECTOR PRINCE GEORGES RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Prince Georges Suitland, Maryland 1 XYES 2 NO permit. 10e. STREET AND NUMBER 10f, ZIP CODE FUNERAL 10g. CITIZEN OF WHAT COUNTRY? 4415 Rena Road #201 20746 as the burial-transit United States 24 hours after death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-If yee, specify Cuban, Maxican, Puerlo Ricen, stc.) 1 — YES 2 ND Specify: 14. RACE — American Indian, Black, White, etc. BALTIMORE, MARYLAND 21215-0020 FDRCES? 1 YES 2: 1 Never Merried 2 Merried BY 3 Widowed 4 Divorced **Black** ETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY use (Give kind of work done life, Do NOT use retired.) Elementary/Secondary (0-12) funeral director, page 5 should be detached for COMPL Barber Private Shop once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname) Cecil Dunlap Ħ Mary Williams notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Williams 4415 Rena Road #201 Suitland, Maryland 20746 pe 20a. METHOD OF DISPOSITION
1 (XBurlal 2 | Cremetion 3 | Removed 4 | Donation 5 | Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, Blate DATE must Washington National 10/25 Suitland, Maryland examiner 21. SIGNATURE OF 22. NAME AND ADDRESS OF FACILITY
Alexander S. Pope Funeral Homes 5538 Marlboro Pike Forestville, Md. the 1 medical 23. PART I. Enter the disasses, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, filled in by shock, or heart failure. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Final Onset and Death the cremation, disease or condition GUNSHOT wownps MULTIPLE completely reaulting in death) other traumatic event, DUE TO (OR AS A CONSEQUENCE OF BOX 6876 bunial, CERTIFICATION and Sequentially list conditions, DUE TO (DR AS A CONSEQUENCE OF) prior to If any, leading to immediate cause. Enter UNDERLYING HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be CAUSE (Disease or Injury that Initiated events the attending phys DUE TO (DR AS A CONSEQUENCE OF) DIVISION OF VITAL RECORDS, P.O. resulting in death) LAST 0 PART II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY PERFORMED? been signed by the AVAILABLE PRIOR TO shows any COMPLETION OF CAUSE OF DEATH? 1 VES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \bowtie UNCERTAIN \square has be Dept. 1 PHYSICIAN: 28. PLACE OF DEATH (Check only or 25. WAS CASE REFERRED TO MEDICAL item certificate h OTHER:
4 □ Nursing Home 5 N Residence HOSPITAL: 1 XYES 2 NO 1 Inpatient 2 ER/Outpatient 3 ODA the or 27. MANNER OF DEATH 28a DATE DE INJURY 28b. TIME DF INJURY 2345 28c. INJURY AT WORK? 28d, DESCRIBE HOW INJURY OCCURED with t marked, (Month, Day, Year) 1 Netural 1 YES SUBJECT BY After 1 2 Accident 28e. PLACE OF INJURY — At home, ferm, street, fectory, office building, atc. (Specify) 3 Suicide DIRECTOR: A 2 hours after d ETED 4 Homicide Home FORESTVILLE 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(e) and ma COMPL TO THE FUNERAL DE filed within 72 h on, in my opinion, death occured at the time, date end piece, and due to the cause(s) and menner as stated, 29c. LICENSE NUMBER 29d. DATE BIGNED (Month, Day. Year) 五五 BE O.C.M.E. OCTOBER 20, 1995 223 36. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JM 111 Penn Street, Baltimore, Maryland 21201 32 AEGISTRAR'S SIGNATURO

3. TIME OF DEATH

7:25AM

2. DATE OF DEATH DAY OCTOBER 23

1 - FOR STATE REGISTRAR

1. DECEDENT'S NAME (Eirst, Middle, Last)

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DIVISION OF VITAL RECORDS, R	
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		4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In	yrs. last birthday			IF UNDER			OF BIRTH		8. BIRTH	PLACE (State or Foreign		
		577-05-6772		t 📉 M 2 🗌 F	78	8 YRS.	MONTHS	DAYS	HOURS	MIN.		. 20 ,	1917	Vire	inia		
3 should		9a. FACILITY NAME (If not instituti	on, give str	eet and number)			9b. CITY,	TOWN (OR LOCATIO	ON OF O	EATH		9c. COU	NTY OF D	EATH		
	OR	Prince Georg	e's l	Hospital			Che	verl	1y				Pri	nce	George's		
Ž.	5	RESIDENCE OF DECED	COUNTY			10c C	TY, TOWN O	B LOCAT	TION					1	444 416155 6174		
physician. burial-transit permit. Pages 1, 2,	DIRECTOR	Maryland P		e George	s		ever1		IIION						10d. INSIDE CITY LIMITS? 1 X YES 2 NO		
perm	IAL	10e. STREET AND NUMBER						101	I. ZIP CODE	E			10g. CIT	IZEN OF V	VHAT COUNTRY?		
ansit	FUNERAL	5825 Dewey S	tree	t				2	20785				U.S	.A.			
ing physician. the burial-tran	BY FUI	11. MARITAL STATUS 1 Never Married 2 Marr 3 W Widowed 4 Divorced	led	12. WAS DECEDEN FORCES? 1 IF YES, GIVE N	YES	2 X NO	1	yes, sp		n, Mexica	n, Puerto	N? (Specify Yes Ricen, etc.)	or No	14. RACE Black Speci			
r attending use as the	03	15. DECEDEN (Specify only high	T'S EDUC	ATION	1	ISa. DECEDENT	S USUAL OC	CUPATR	ON	_	161	. KIND OF BUS	SINESS/INI	DUSTRY	WILLE		
0 =	COMPLET	Elementary/Secondary (0-12)	est grade t	College (1-4 or 5		Me. Do NOT		luring mo	ost of workin	rg	T.	Vashing	ton	Navv	Yard		
the hospital detached to once.	OM	17. FATHER'S NAME (First, Middle,	Last)						16. MOTH	HER'S NA		Middle, Maiden	_	2,007	1010		
at be	BE C	Clarence H.	Rhod	es					Erm	a K.	Lan	nb					
5 should notified	0 8	19e, INFORMANT'S NAME (Type/P	,			19b. MAILIN	G ADDRESS	(Street a	and Number	or Rural	Route Num	ber, City or Tow	n, State, Zij	o Code)			
y be re page 5:	F	Bernice O'Br	ien			6007	Hawth	orne	e Str	eet,	Che	everly,	Mar	ylan	d 20785		
e 6 may ector, pag must b		20a. METHOD OF DISPOSITION 1 X Burlel 2 Cremation 3		val from State	cemet	PLACE AND DATE	other place!				DAT			City or To			
age 6 direct		4 ☐ Donation 5 ☐ Other (Special Science of Funeral Set		NOTE A	- For	rt Line	oln C					5 Bre	ntwo	od, N	Maryland		
death. Page 6 may be retained I funeral director, page 5 should I. examiner must be notified		21. SIGNATURE OF FUNERAL SE	TVACE LICE	L	/	/	F:	ranc	ND ADDRES	asch	i's S	Sons Fu	inera	1 H	ome, P.A.		
hours after de ed in by the fu or removal.		Hlonsh	ane	e Has	ch										e, MD 20781		
certificate be executed within 24 hading physician and completely fille Hygiene prior to burial, cremation, ir other traumatic event, the	ERTIFICATION	IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST Land CAUSE (Disease or injury that initiated eventa resulting in death) LAST Land CAUSE (Disease or injury that initiated eventa resulting in death) LAST											Onest and Death Wr Lease Flary				
that the death ned by the atter th and Mental any injury, o	O	PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part i, 24s. WAS AN AUTOPSY PERFORMED? AMALABLE PRIOR TO															
ind by	EDICAL					•						PERFOR	MED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE		
sign sign fea	율	1 VES 2 NO												OF DEATH? 1 YES 2 NO			
law requast been bept. of 1	ä	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN											1				
	25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)																
CIAN: ertifica the Sta or Ite	HYSIC	1 YES 2- NO	NO THER: 1 Inpetiant 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Residence 8 Other (Specify)														
this c with	<u>D</u> .	27. MANNER DF DEATH 1. Naturel 5 Pend 2 Accident Inves	ing tigation	28a. DATE DE (Month, L		28b. TI	ME OF JURY M	28c. INJ WC	JURY AT DRK? YES 2	NO	28d. DE	SCRIBE HOW II	NJURY OC	CURED			
TE afte	ETED B	3 Suicide 6 Coul	i not be mined	28e. PLACE C building	F INJURY atc. (Specify	- At home, farm	, atreet, facto	ory, offic	C A		28f. LOC City	CATION (Street of Town, State)	and Numbe	r or Rural F	Poute Number,		
Z ZZ =	COMPLE	One)		IAN: To the best of a											and manner as stated,		
TO THE HOSPI' TO THE FUNER De filed within	BE C	296. SIGNATURE AND TITLE OF	CERTIFIER	7					29c, LICE	ENSE NUI	MBER	-0	29d. DA1	E SIGNED	(Month, Day, Year)		
TO THE TO THE De filed MPOR	0	anai	fere	1					1	47	25	7		10/	23/95		
0	-	30. NAME AND ADDRESS OF PER L/PISHRE	E	NAY	SE OF DEAT	H (ITEM 27) (17)	Print)	L	and	lou	er	Rd,	Ch	ene	ely,		
	31. DATE FILED (MONTH, Day, Year) OCT 251995 Julia Daylear hardell										(
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

EINHORN

beath. Page 6 may be retained by the hospital or attending physician. If thereal director, page 5 should be detached for use as the burial-transit permit, Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS P.O. BOX 68760

DALLIMONE, MARTLAN	hours after death. Page 6 may be retained by the hos	fled in by the funeral director, page 5 should be detach , or removal.	a medical examiner must be notified at once.
Consider of the Property, T.C. Box 68780	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hos	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detach be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEDENT'S NAME (First, Middle, Last)	Cara Virginia Fleming December 29,1995 Signed to Death Signed to Death December 29,1995 Signed to Death Signed to De		1 - STATE REGISTRAR	STATE OF MARY		TMENT OF H		MENTAL HYGIEN	E			
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29b. PLACE OF INJUSTY— All home, farm, street, factory, office 29c. CERTIFFIER (Check only) 2 MEDICAL EXAMPLE: In the Plants of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. SIGMATURE AND TITLE OF CERTIFIED 20b. SIGMATURE AND TITLE OF CERTIFIED 20b. NAME AND ADDRESS OF BERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)	Section Sect	BE COMPLETED BY PHYSICIAN: MEDICAL	PART II. Other significant condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL: EXAMINERY 1 YEL 2 MO 27. MANNER OF DEATH 1 Heliumi 5 Pending investigation 3 Buicade 6 Could not be defermined 29a. CERTIFIER 1 CERTIFYING PHYS (Check only one) 29b. SIGMATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF BERSON WITH	PRIBUTE TO CAUSE (HOSPITAL: 1) Impatient 2 ERVou 28a. DATE OF INJURY (Moreth, Day, Mar) 39a. PLACE OF INJURY building, etc. (Sp ER; fin the Marje of examination BO COMPLETED CAUSE OF D	OF DEATH YE. 26. PLACE OF DEATH inspetient 3 DOA 26b. Time RLA TY — All home, farm, st social The death occurrent from and/or investigation DEATH (ITEM 27) (Type.	S NO NO NO NO NO NO NO NO NO NO NO NO NO	UNCERTAIN B S Residence of the state of t	PERFORM 1 YES 2 5 Other (Specify) 38d. DESCHIBE HOW IN 28f. LOCATION (Street at City or Sour., State) to the cause(s) and manu- time, data and place, and BER	JURY OCCURED at Number or Rural I for as stated. due to the cause's POCt.	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Some Number and manner as statest. (Month, Dey, Year)		
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I'V . AN . 9.0 2.00 . The state of the

3. TIME OF DEATN

Approximata **Onset and Dasth** 12 h-

24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?

Srorath St

26

2. DATE OF DEATH MONTH

1 - FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

۵ DIVISION OF VITAL BECORDS

2

		Marlene Rer		eman					Jň	October	26. 1	995	3:00 P
		4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. les	t birthday)	IF UNDER		IF UNDER		7. DATE OF BIRTH (Month, Day, Year)		8. BIRTI Count	PLACE (State or Foreign
29	1	219-46-2135	1 🗆 M 2 💢 F	47	YRS.	MONTHS	DAYS	HOURS	MIN.	May 22,19	48	Mar	yland
should		8e. FACILITY NAME (If not institution, give	street end number)			9b. CITY,	TOWN C	R LOCATIO	ON OF DEA	ATN	9c. COU	NTY OF D	EATN
2,	СТОЯ	Frederick Memor	rial Hosp	ital		1	Fred	eric	k		Fre	deri	ck
	ן ק	RESIDENCE OF DECEDENT											
nit. Pages	DIRE	Maryland 10b. count	Frederi	ck	10c. CIT	Fred							10d. INSIDE CITY LIMITS? 1 X YES 2 NO
permit.	AL	10e. STREET AND NUMBER					101	ZIP CODE	_		10g. CIT	IZEN OF V	WHAT COUNTRY?
n. ansit	l iii	32 N.	Pendleto	n Court				217	03		Uni	ted	States
fing physician.	BY FUNERAL	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced	FORCES? 1	T EVER IN U.S. AR	MED	1 !!	yes, sp	ENDENT O	n, Mexican,	C ORIGIN? (Specify Ye, Puerto Ricen, etc.)	s or No-	Black	American Indian, k, White, atc.
r attending use as the	ED	15. DECEDENT'S EDU	CATION	16e. DE	CEDENT'S	USUAL OC	CUPATIO)N		16b. KIND OF BU	JSINESS/INI		
- 6 -	COMPLETED	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5	Aria .	ive kind of v Do NOT us	vork done d e retired.)	uring mo	st of workin	9	Mont			
hospital hospital sached for	필	12			ome	Maint	ane	nce	Super				ent
the hospid detached	5	17. FATHER'S NAME (First, Middle, Last)								E (First, Middle, Malder		-	
# 8 &	BEC	AUSTIN	EUGENE	DIGGS						Arlene S		272	
retained 5 should notified		19e. INFORMANT'S NAME (Type/Print)			. MAILING	ADDRESS	(Street e			oute Number, City or Tox			
5 5 5	욘	DANIELLE R. SNOV	DEN							Frederic			1703
2 2 0		20a. METHOD OF DISPOSITION		20b. PLACE							CATION -		
age 6 ma director, 1		1 Burtal 2 Cremation 3 Rem 4 Donation 5 Other (Specify)	noval from State	Fairy	metory or of	cemet	erv			10-31 Fr			
Pag al dir		21. SIGNATURE OF FUNERAL SERVICE LI	ceydage	/					SS OF FACI	Stauff			
tuneral funeral		V al	1~ 1										
2 2 2 3		20/24772 500000	1	5/		16	521	Opos	sumt	own Pike/	Fred	eric	k,Md.21702
3 -2 . 9		23. PART 1. Enter the diseases, or shock, or heart failure.	List Dniy Dne car	se on each line	ath. Do n	ot enter t	the mod	de of dyli	ng, auch	aa cardiac or reap	iratory an	rest,	Approximats Interval Batwe
		IMMEDIATE/CAUSE (Final disease or condition											Onset and Da
within 24 pletely fille cremation,		resulting in death)	a. DUE TO	501-3	60-	4	1	011	10-	=			126-
mecuted and con burial,	8	Sequentially list conditions,	b	to are h	0/	ne	4 2	40.	710				12h-
S S E	ERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING											53
	일	CAUSE (Disease or Injury that initiated events our following that initiated events											300
nding phy Hygiene s	E	that initiated events resulting in death) LAST											
	E		d	1- 000	5 C	C_6	سد والد	c/-	200-	75			18 000
the dear of the aff of Menta		PART ii. Other significent condition	na contributing to	death but not r	esuiting I	n the unc	deriying	ceuse g	iven in P	ert I. 24a. WAS AN	AUTOPSY	24b.	WERE AUTOPSY FINDING
# 4 5 5	ICAL	-/1000 010		0015						PERFD			AMILABLE PRIOR TO COMPLETION OF CAUSE
Sign Sign	EDI						3.0	0.3 23		1 TES	2 100		OF DEATH?
- o e e	Σ	DID TOBACCO USE CONT	PIRLITE TO CA	TISE OF DEV	TH VE	S 🗆 N	ΙΩП	LINICI	EDTAINI				1 YES 2 NO
23 Pe 8 Fe	NA N	25. WAS CASE REFERRED TO MEDICAL	KIBOTE TO CA		E OF DEAT			UNC	EKIAIIY	ш			
N: The ficate base State	SICIA	EXAMINER?	HOSPITAL:			OTHER							
PHYSICIAN: The this certificate h with the State I with the State I when the them inked, or Item	РНҮ	27. MANNER OF DEATN	28s. DATE OF		28b. TIME		ng Home 26c, INJU	_		Other (Specify)	N HIM OO	21050	
NG PHYS fler this ceath with		1 Netural 5 Pending	(Month, D	lay, Ybar)	INJ	JRY M	WOI	PK?		28d. DEŞCRIBE NOW I	INJUNY OC	COHED	
	B	2 Accident Investigation 3 Suicide B Could not be	28a, PLACE D	F INJURY — At ho	ne form e	Iraal facto		2 2	_	001 1 001TION (O)			
TTEND TOR: / after d	9	4 Homicide B Could not be	building,	etc. (Specify)	110, 101111, 0	rrees, recto	ry, ornce			261. LOCATION (Street City or Town, State)	end Number)	or Hural H	loute Number,
OR ATTEN OIRECTOR: hours after Item 28 Is	LET	29e. CERTIFIER											_
	OMPL	(Check only								the cause(e) end ma			
		2 MEDICAL EXAMINE	R: On the baels of e	xamination end/or i	nvestigation	ı, in my op	inion, de	eth occure	ed at the ti	me, date end place, er	nd due to th	e ceuse(e	end manner ee stated.
THE HOSPI TO THE FUNEP OF filed within	E C	296. SIGNATURE AND TITLE OF CERTIFIE						29c. LICE	NSE NUMB	ER	29d, DAT	E SIGNED	(Month, Day, Year)
5 5 5 W	8	Ver a	La.	669 65				219	469	6	10		26 1995

30. NAME AND ADDRESS DF PERSON WHD COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

410

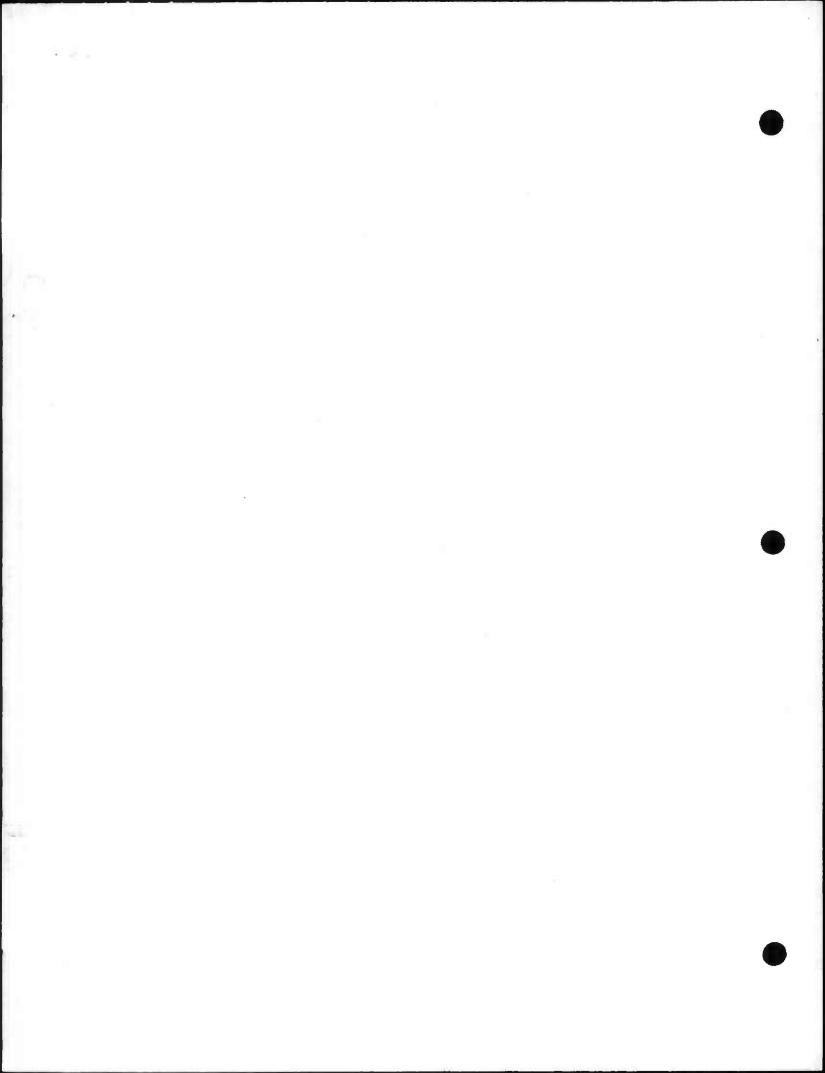
32. REGISTRAR'S SIGNATURE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

DHMH-16 Rev 1/89

1995

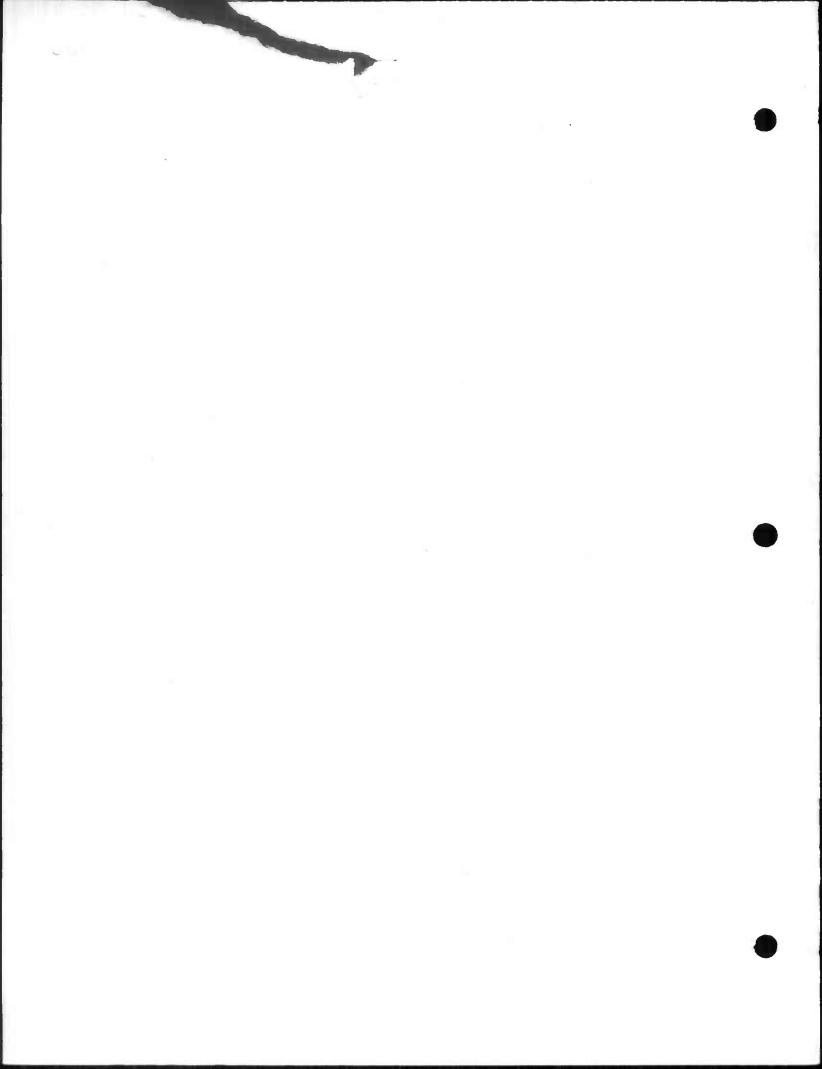
MODIX



THE HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 22 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNETAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 22 hours after death. Present the scrificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hyghere prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

Ü	1. DECEDENT'S NAME (First, Mi	iddle, Last)								2. DATE OF DEATH			3. TIME OF DEATH
	Ronald Ri		d Fish	er						Oct. 14	.199	YEAR	5:45A M
	4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In yrs. las	t birthday)	IF UNDE		IF UNDER	,	7. DATE OF BIRTH	177	6. BIRTN	PLACE (State or Foreign
- 6	212-32-703	31	™ M 2 □ F	59	YRS.	MONTHS	DAYS	HOURS	MIN.	(Month, Day, Year) Apr. 30	1036	Countr	"
_	9a. FACILITY NAME (If not institu	ution, give str	eet and number)			9b. CITY	r, TOWN	OR LOCATI	ON OF DE			INTY OF D	
O.	Chestertow Rehab Cen	n Nu	ırsıng	and		C	hes	tert	own			K	ent
5		DENT b. COUNTY											
E	Maryland	B. COUNTY				alt							10d. INSIDE CITY LIMITS?
	10e. STREET AND NUMBER					ull							1X YES 2 NO
RA	7900 Rolli	na V	iew Av	enue			10	of. ZIP COD	212.	36	10g. CIT		S.A.
FUNERAL DIRECTOR	11. MARITAL STATUS	T	12 WAS DECEDEN	T EVED IN II C AD	MED	142	WAS DE	OFNIDENT (IC ORIGIN? (Specify Yes			
	1 Never Married 2 Ma		FORCES? 1	YES 2 PA	10		If yes, s	pecify Cuba	ın, Maxicai	, Puarto Rican, atc.)	or No-	Black	— American Indian, , White, atc.
B⊀	3 Widowed 4 Divorce	d	ir res, diver	WIN ON DAILS			1 L TE	s 2XIXNO	Specify	:		Speci	™ White
COMPLETED	15. DECEDE (Specify only his	ENT'S EDUC	ATION (completed)	18a. DE	CEDENT'S	USUAL O	CCUPATI	ION ost of working	200	16b. KIND OF BUS			
9	Elementary/Secondary (0-12)		College (1-4 or 5	+) life.	Do NOT us	e retired.)			2	Social			
MP	11			Cla	ims	Exa	ami	ner		Admini	istr	atio	on
	17. FATHER'S NAME (First, Middle	le, Last)		McColl	امددها	h		18. MOT		ME (First, Middle, Maiden			
BE		-								elyn Hoff			
2	19a. INFORMANT'S NAME (Type) Russell Wi		m Fich	198						oute Number, City or Town			- M- 21226
	20m. METNOD OF DISPOSITION	_	III LISII					-					e,Md.21236
	1 SpBurlel 2 Cremation 4 Donation 5 Other (Sp	3 🗌 Ramo	vat from State	cemetery, cre	matory or of	har placa)			Oc:	18,1995	CATION —	City or To	wn, State
	21. SHUNATURE OF FUNERAL SE		NSEE ,	Ches	ter	Dei	net	PY ADDRE	SS OF FAC	CF	est	erto	own, Md.
l	NA	1/	2/.//	0)	T	mc	Helf	enbe	ein Funer	cal	Home	es, P.A.
	Auce	7.4	y eng 2	my een		11:	30	Spee	r Ro	d. Cheste	erto	wn.	Md.
	23. PART I. Enter the disease shock, or hear	eaes, or co t fellure. L	int only one ceu	t caused the de lee on each line	ath. Don	ot enter	the mo	ode of dy	ing, auch	ea cerdlec or reapl	ratory ar	reat,	Approximate interval Batween
1	IMMEDIATE CAUSE (Final disease or condition				,			1					Onset and Death
ŀ	resulting in deeth)	a	cereb		lac	acc	, de	1					
DUE TO (OR AS A CONSEQUENCE OF):													
ō	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):												
Z	if sny, leading to immediate cause. Enter UNDERLYING												
Ē	CAUSE (Disesse or injury that initisted events	1	DUE TO	(OR AS A CONSEC	UENCE OF	7:							
盟	resulting in death) LAST	d.											
	PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24s. YAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS												
MEDICAL	PERFORMED? COMMIT												AVAILABLE PRIOR TO
	1 YES 2 THE COMPLETION OF CAUSE OF DEATH?												
- 1	A 12 heimer's disease												
NA I	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)												
PHYSICIAN:	EXAMINER?		HOSPITAL:	ER/Outpatient 3	DOA	OTHE		no 5 🗆 Ro	eldence	B Other (Specify)			
ξI	27. MANNER OF DEATH	-	28a. DATE OF	INJURY	28b, TIME	OF	28c. IN.	JURY AT		28d. DESCRIBE HOW IN	NJURY OC	CURED	
BY F	1 Natural 5 Pen 2 Accident Inve	iding estigation	(Month, D	ay, rear)	ILUI	M		ORK? YES 2	NO				
	3 Suicide 8 Cou	ald not be	28a, PLACE O	F INJURY — At hor atc. (Specify)	me, ferm, s	treet, fec	tory, offic	CA		281. LOCATION (Street a	nd Numbe	r or Rural A	loute Number,
COMPLETED	4 Homicide data	armined		(City or Town, State)			
2	29a, CERTIFIER (Check only	ING PHYSIC	IAN: To the best of	my knowledge, de	eth occurre	d at the t	ilme, detr	and place	, and dua	to the cause(a) and men	ner aa sta	nted.	
8										time, data and place, and) and manner as stated.
	296. SIGNATURE AND TITLE OF	CERTIFIER		011			_	29c. LICI	ENSE NUM	BER	29d, DAT	TE SIGNED	(Month, Day, Year)
8 E		m	Bronn	AN MC)				35		> /	0-1	7-95
임	30. NAME AND ADDRESS OF PE	RSON WHO	COMPLETED CAUS	SE OF DEATH (ITEM	27) (Type,	Print)					-	. ,	, , ,
	Michael	L 1	Siene	nteld	- 11	n.T) (The	ste	rtown 1	md	- 6	21620
~ l	31. DATE FILED (Month, Day, Year	r)		R'S SIGNATURE									
K II	OCT 18'95		Julia Da	vidson-Rano	La 22_								



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CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF OEATN 3. TIME OF GEATH YEAR FullerTon Sept.24 9:30P 1995 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. lest birthday) 7. DATE OF BIRTH (Month, Day, Year)

July 1,1906 Pennsylvania IF UNDER 1 YEAR 196-05-1290 89 DAYS HOURS 1X M 2 | F YRS. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATN 9c. COUNTY OF DEATH DIRECTOR Meredian, Corsica Hills Queen Anne's Centreville RESIDENCE OF DECEDENT 10e. STATE 10h. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Kent Betterton permit. 1 YES 2 X NO 10a. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? Page 6 may be retained by the hospital or attending physician. al director, page 5 should be detached for use as the burial-transit 101 Main Street 21610 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. RACE — American Indien, Black, White, etc. FORCES? 12 YES 2 NO IF YES, GIVE WAR OR DATES 1 Never Married 2 Merried BY 1 TES 2 NO Specify: ₩Idowed 4 Divorced Specify 1920 White ETED. 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade comp in by the funeral director, page 5 should be detached for removal. Elementary/Secondary (0-12) College (1-4 or 5 +) Reading Railroad Railroad Worker COMPL 12 notified at once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname) George Fullerton Cora Alspach BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19th MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 21610 101 Main St. p.O. Box 248 Betterton, Md. 9 George J. Williams, Jr. pe 20a. METNOD OF DISPOSITION
1 ☐ Burlel 2 ※ ※ ※ Fermetion 3 ☐ Rent
4 ☐ Donation 6 ☐ Other (Specify) of Disposition (Name of Sept. 25, 19 25, Location — City of Te Crematory Sept. 25, 19 Baltimore, 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State must Metro examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSES 22. NAME AND ADDRESS OF FACILITY Tom Helfenbein Funeral Homes, P.A. Md.21620 130 Speer Rd., Chestertown, medical 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. and completely filled in by burial, cremation, or remo Interval Between IMMEDIATE CAUSE (Final Onset and Death the disease or condition_ within 24 Kera resulting in death) other traumatic event, CERTIFICATION Sequentially list conditions, prior to b QUE TO (OR AS A CONSEQUENCE OF): has been signed by the attending physician Dept. of Health and Mental Hygiene prior to if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 9 Injury, PART ii. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PERFORMED? any AVAILABLE PRIOR TO ombog toon COMPLETION OF CAUSE 1 YES 2 NO 1 YES 2 NO 6 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: Dept. 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) State 1. r this certificate h h with the State [**EXAMINER?** HOSPITAL OTHER:
4 Mursing Home 5 Residence 6 Other (Specify) PHYSICIAN: 1 YES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 0 27. MANNER OF DEATH 28e. OATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 26b. TIME OF INJURY 28d. OESCRIBE HOW INJURY OCCURED Is marked, 1 Naturel 1 YES 2 NO After death BY 2 Accident Investigation ATTENDING 28e. PLACE OF INJURY — At home, farm, street, fectory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, Stete) COMPLETED 6 Could not be DIRECTOR after 28 Is 4 Homicide hours Hem 8 29e. CERTIFIER 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) and manner ee stated. FUNERAL Within 72 h 2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(e) and manner as stated. TO THE HOSPITA
TO THE FUNERA
De filed within 7. 29b. SIGNATURE AND TITLE OF CERTIFIER BE 29c. LICENSE NUMBER 29d, DATE SIONED (Month, Day, Year) 1. alum, 71 MD 02/3/3 9 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) WUN J. BEGISTMAR'S SIGNATURE Julia Daydson-Handall

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BALTIMORE, MARYLAND 21215-0020

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending	JOST HETERAL PRINCIPAL PRINCIPAL PROPERTY AND A CONTRICTORS. THE PROPERTY OF THE PROPERTY WAS A COMPINED WITHOUT THE PROPERTY OF THE PROPERTY	be med when it nows after death with the State Dept. Or negatified and wented mygleric prior to bunda, cremation, or removal. IMPORTANT: If I fem 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
The law requires that	ate has been signed	tom 23 shows an
NDING PHYSICIAN:	: After this certific	is marked, or it
TAL OR ATTEN	RAL DIRECTOR	If Item 28
TO THE HOSP	TO THE FUNE	IMPORTANT
	1	

											9	5 :	33940
	1 - STATE REGISTRAR	STATE OF M	MARYLAND /	DEPAR ERTIF	TMEN	T OF H	DEAT	AND N	MENTA	REG. NO.	E		
	1. DECEDENT'S NAME (First, Middle, Li	est)					*		2. DATE	OF DEATH			3. TIME OF DEATH
		an Francoi	5						Oct	ober 2		995	1:45A M
	4. SOCIAL SECURITY NUMBER	5. SEX	8. AGE (In yrs. las	st birthday)		ER 1 YEAR	IF UNDER		7 DATE	OF BIRTH		a SISTH	IPLACE (State or Foreign
-	433-27-9692	1 □ M 2 🖾 F	88	YRS.	MONTHS	DAYS	HOURS	MIN.	Nov	th, Day, Year)	1906	Lou	m iisiana
	9a. FACILITY NAME (If not institution, gr	live street and number)			9b. CIT	Y, TOWN O	OR LOCATIO	ON OF DE				JNTY OF D	
8	Doctors' Commun	ity Hospit	.a1	1	Lar	nham					Pri	nce	George's
DIRECTOR													000280
2			1 _			OR LOCAT							10d. INSIDE CITY LIMITS?
		nce George	S	Lan	ham-	-Seab							1 X YES 2 NO
FUNERAL	10e. STREET AND NUMBER					101	ZIP CODE	_			10g. CIT	IZEN OF W	VHAT COUNTRY?
NE	9601 Dubarry Av						2070					S.A.	
5	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDEN FORCES?	T EVER IN U.S. AR	MED	13.	WAS DEC	ENDENT O	F HISPAN	IC ORIOII	N? (Specify Yea Rican, etc.)	or No-	14. RACE Bleck	E — American indian, k, Whita, etc.
ВУ	3 Wildowed 4 Divorced	IF YES, GIVE W					2 X NO			resours, brees,		Specif	lly:
	15. DECEDENT'S		100 00	200					1				Black
COMPLETED	(Specify only highest g	grade completed)	(GI	ECEDENT'S Sive kind of v	work done	during mos	IN st of workin	ng	168	. KIND OF BUS	INESS/IN	DUSTRY	
7	Elementary/Secondary (0-12)	College (1-4 or 5	+)	nemak	,	,				Own H	OMA		
N.	17. FATHER'S NAME (First, Middle, Last)		11011	Temak	,61								
S	The second of th	own						HER'S NAM Lanna		Fobbs			
88	WILLIAM DI	OWII											
2		C								ber, City or Town			2000
	Daniel Francois	, Sr.	1					е, L	_		_		20706
	1 Burial 2 Cremation 3 R		20b. PLACE A	LINC	of Dispos	Ceme	meof tery	10/2	25/9	5 Bre:	n two	od, N	Maryland
	21. SIONATURE OF FUNERAL SERVICE	LICENSEE	0.		22.	. NAME AN	D ADDRES	SS OF FAC	PILITY	77	- 1		
	> 7/ Vana	larce	Laces	/									e, P.A.
	23. PART I. Enter the diseases,	_	t caused the de	ath Do r	4 /	739 B	alt1	more	Ave	.,Hyat	tsvı	lle,	MD 20781
	shock, or heart fallu	ire. List only one cau	ise on each line).	IOI WITE	T LITTO TO S	as or up.	ng, auci	1 85 0811	OHEC OF LESSY!	ratory an	rest,	Approximats Interval Between
	IMMEDIATE CAUSE (Final disesse or condition	Aspi	ration										Onset and Death
1	resulting in death) DUE TO (OR AS A CONSEQUENCE OF)												10/2493
_	Inability to Swallow												
CERTIFICATION	Sequentially list conditions, Due to (or As A consequence of):												70/73
¥	If any, leading to Immediate cause. Entar DEE 10 (ON & A CONSCIUENCE OF): CAUSE. CHIEF CHE CONSCIUENCE OF): Cerebrovas cular Accident												j j
E I	CAUSE (Disease or Injury that Initiated events DUE TO (OR AS A CONSEQUENCE OF):												1
토	resulting in death) LAST												
2	PART II. Other significent conditions contributing to death but not resulting in the underlying source of the significant conditions contributing to death but not resulting in the underlying source of the significant conditions contributing to death but not resulting in the underlying source of the significant conditions contributing to death but not resulting in the underlying source of the significant conditions contributing to death but not resulting in the underlying source of the significant conditions contributing to death but not resulting in the underlying source of the significant conditions contributing to death but not resulting in the underlying source of the significant conditions contributing to death but not resulting in the underlying source of the significant conditions contributing to death but not resulting source of the significant conditions contributing to death source of the significant conditions contributing to death source of the significant conditions contributing source of the significant conditions contributing source of the significant conditions contributing source of the significant conditions contributing source of the significant conditions contributing source of the significant conditions contributing source of the significant conditions contributing source of the significant conditions conditions contributing source of the significant conditions conditions contributing source of the significant conditions contributing source of the significant conditions contributing source of the significant conditions contributing source of the significant conditions conditions contributing source of the significant conditions contributing source of the significant conditions conditions conditions contributing source of the significant conditions contributing source of the significant conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions												
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ă									_	1 TYES 2	NO M		COMPLETION OF CAUSE OF DEATH?
B									_				1 - YES 2 - NO
PHYSICIAN: MEDICAL	DID TOBACCO USE CON	NTRIBUTE TO CA	USE OF DEA	TH YE	is 🗆	NO 🔯	UNC	ERTAIN	1 🗆				
5	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	28. PLAC	CE OF DEAT									
XS.	1 TYES 2 T NO		ER/Outpatient 3	□ DOA	4 Nur	FR: Insing Home	o 5 □ Ra	sidence	6 🗆 Othe	er (Specify)			
F	27. MANNER OF DEATH	28a. DATE OF (Month, D.		28b. TIMI	E OF	26c. INJU	URY AT		26d. DES	SCRIBE HOW IN	JURY OC	CURED	
ВУ	1 Natural 5 Pending 2 Accident Investigation				М		ES 2 [] NO					
60	3 Suicide 6 Could not	building.	of INJURY - Al hor	me, lerm, r	street, fac	tory, office			261. LOC	ATION (Street a or Yown, State)	nd Number	r or Rural A	loute Number,
EE	4 Homicide datermined	1	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,						City	or lown, State)			
7 1	29a. CERTIFIER 1 CERTIFYING PH	HYSICIAN: To the beat of	my knowledge, da	eth occurr	ed at the	time, data	and place,	and dua	lo lhe cau	use(s) and man	ner as sta	ted.	
COMPL		MINER: On the beats of a) and manner as stated,
O H	SIGNATURE AND TITLE OF CERTI							NSE NUM					(Month, Day, Year)
0	W Ohner	Vone.					02464						L 24, 1995
2	30 NAME AND ADDRESS OF PERSON	WHO COMPLETED CALL	00.00.00.00.00.00										,

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type. Print)

Dr. Dora M. Mamodes ene 4000 Mitchelville Rd #318 Bowie, MD 31. DATE FILED (Month, Dey, Year)
OCT 25 1995 32 REGISTEAR'S SIGNATURE

THE HOSTIAL OF ALCHONIN TRIBOCATION. The law requires that the detail continued by executive within the FLUKERAL US ALCHONING TRIBOCATION. The law propriate has been signed by the attending physician and completely finded in by the functal director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should within 72 hours after death with the State Derty, or Health and Mental Hygiene prior to burial, cremation, or removal. **PORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.		3 should		
INERAL DIRECTOR: After thin 72 hours after death INT. If Item 28 is mar		1. 2.		
JOHN AND THE MINE THE THE THE THE THE THE THE THE THE TH		Pages		
JOHN AND THE MINE THE THE THE THE THE THE THE THE THE TH	out a tion ocati. Tage o may be retained by the incepted of attending physician.	led in by the funeral director, page 5 should be detached for use as the burial-transit permit.	, or removal.	medical examiner must be notified at once.
INERAL DIRECTOR: After thin 72 hours after death INT. If Item 28 is mar	rate he executed within	physician and completely fil	e prior to burial, cremation	er traumatic event, the
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JOHN AND THE MINE THE THE THE THE THE THE THE THE THE TH	וועב ופא ובלחוובי ר	rte has been signer	ate Dept. of Health	em 23 shows at
INERAL Thin 72	JING PRISICIPIN.	After this certifica	death with the St.	mari
REEZ	INT OH MIENE	PAL DIRECTOR:	72 hours after (If Item 28 is
	2	THE FUNER	in filed within	THIPORTANT.

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	FOR 1 - STATE REGISTRAR	STATE OF M		DEPAR					AENTA				
	1. DECEDENT'S NAME (First, Middle, Last)		CI	SNIII	ICAT	E OF	DEA	n l	2. DATE	REG. NO.			3. TIME OF DEATH
	JESSE FELIX								MONT	Oct	21,19	95ª	4:57 PM M
		5. SEX	6. AGE (In yrs. le:	st birthday)		R 1 YEAR				OF BIRTH	1	8. BIRTHP	LACE (State or Foreign
	439-34-9754	1 XM 2 - F	67	YRS.	MONTHS	DAYS	HOURS	Merec.	Oc	h, Day, Year)	1928	Natch	nez, Miss.
	9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DE											TY OF DE	
POP	Calvert Memorial		P	rince	Fre	ederi	ick		C	alve	rt		
FUNERAL DIRECTOR	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY						ION						10d. INSIDE CITY
DIR				Was	hing	ton,	D. C					LIMITS?	
AL	10e. STREET AND NUMBER						ZIP COD				10g. CITIZ	EN OF W	AT COUNTRY?
ER	145 T Street, N.	W.					200	01			ı	J.S.A	
5	11. MARITAL STATUS	2. WAS DECEDENT	EVER IN U.S. AF	NO	13.					N? (Specify Yes	or No-	14. RACE -	- American Indian, White, etc.
ВУ	1 Never Married 2 🔀 Merried 3 Widowed 4 Divorced	IF YES, GIVE W	YES 2 AR OR DATES					Specify		ricani, etc.)			Black
	15. DECEDENT'S EDUCA	TION	16a, DE	ECEDENT'S	USUAL C	CCUPATIO	M		161	. KIND OF BU	RIMESS/IND	IISTRY	
ETE	(Specify only highest grade or Elementary/Secondary (0-12)	College (1-4 or 5 +	(6	Sive kind of Do NOT u	work done	durina mo		ng					
PL	12	4		gal L	and	Spec	iali	st		Feder	cal Go	overn	ment
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				-				ME (First,	Middle, Maiden	Sumama)		
BE (Noah Felix Ire								e Ca	lvin			
TO E	19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)												
	Alice Felix								ngto	n, D.C			
	20e. METHOD OF DISPOSITION 1 Remov	al from State	20b. PLACE other pi	lace)							CATION —		
	4 Donetion 6 Other (Specify)	eser.		Га	_	awn (SS OF FAC	OII ITW	Ro	ckvil	re, r	na.
	1111 G. C	.//			1 ***	TOTAL PAR	ID ADDITE	SS OF FAL		razier	's Fu	ınera	1 Home, Inc
_	July 3	47	in	_	3	89 R	hode	Is1	and	Av., NW	.Wash	ingt	on, D.C.
	ahock, of heart fellule. List only one cause on each line.											Approximata Interval Between	
	IMMEDIATE CAUSE (Final												Onset and Death
	disease or condition resulting in death) Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF):												
_			nary Ar			0000							
ERTIFICATION	Sequentially list conditions, if any, leading to immediate		OR AS A CONSE			ease			-				
CAT	cause. Enter UNDERLYING												
F	CAUSE (Disease or Injury that initiated events	DUE TO	(OR AS A CONSE	OUENCE O	F):								
	resulting in death) LAST												
CC	PART II. Other algnificant conditions	contributing to	death but not	resulting	in the u	nderlyin	Cause	given in	Part I.	24s. WAS AN	AUTOPSY	24b. 1	WERE AUTOPSY FINDINGS
SA	Diabetes									PERFO			AVAILABLE PRIOR TO COMPLETION OF CAUSE
ED	Hypertension									1 TYES 2	X NO		OF DEATH?
PHYSICIAN: MEDICAL													
SIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?						ACE OF E	DEATH (Ch	eck only o	ne)			
SIC	**	HOSPITAL: I ☐ Inpatient 2 🖸	ER/Outpatient	3 🗆 DOA	4 Nu		• 5 🗆 R	esidence	6 🗆 Oth	er (Specify)			
PH	27. MANNER OF DEATH	28a. DATE OF (Month, De	INJURY lly, Year)	28b. TIN	IE OF	28c. INJ WO	URY AT		28d. DE	SCRIBE HOW	NJURY OCC	URED	
BY	1 Natural 5 Pending 2 Accident Investigation				М		YES 2 [NO					
8	3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE Of building,	F INJURY — At he atc. (Specify)	ome, farm,	street, fac	ctory, offic	•			CATION (Street or Town, State)		or Rural Ro	oute Number,
E													
COMPLET	(Check only												and the same
8	2 MEDICAL EXAMINER:	Out the needs () (6)	antimetron englor	arvestigati	on, in my	opinion, d				e una piece, ei			And the second second
BE	296. SIGNATURE AND TIPLE OF CERTIFIER	- 2	M	V)			1935					(Month, Day, Year) 3,1995
0	0-110	1			/		+	- , , , ,	9		1	1664	J, 1777

2141 K St., N.W., Washington, D.C., 20037

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Elliott Aleskow, MD, 2141 K St., N.W.,

32. REGISTRAR'S SIGNATURE

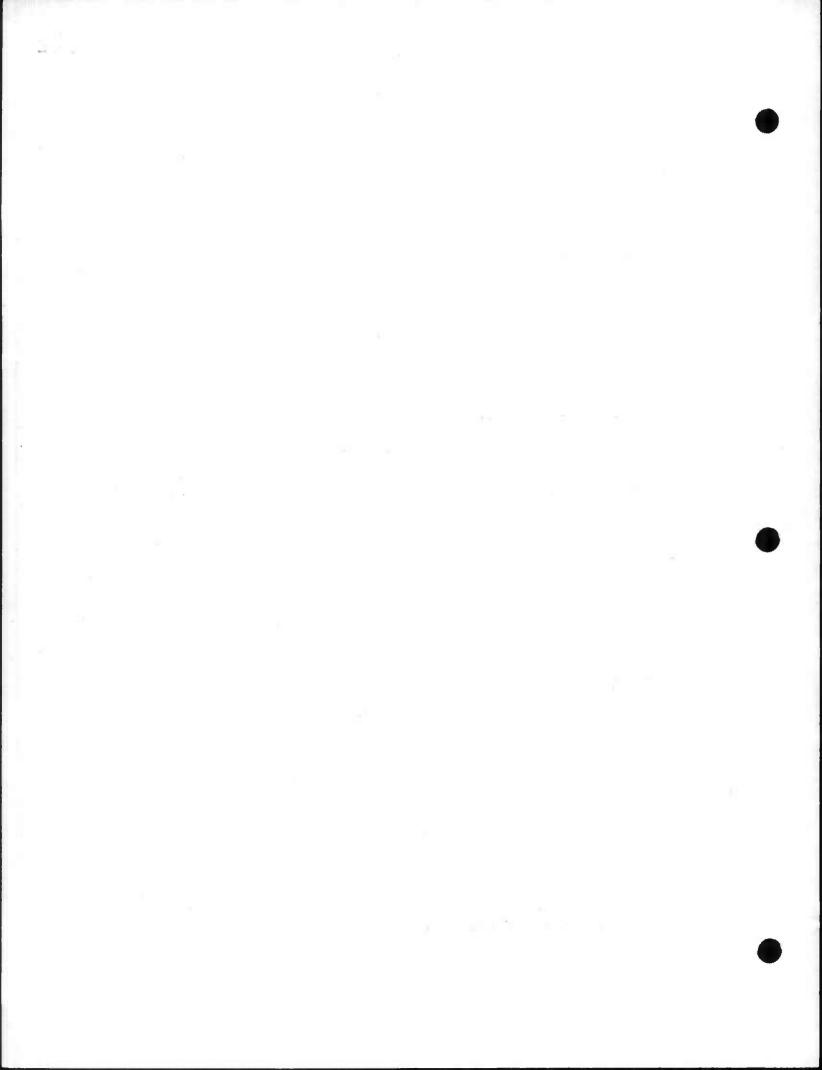
31. DATE FILED (Month, Day, Year)

OCT 25 1995

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	1 - STATE REGISTRAR			CERTIF	TMENT			REG. NO		
	1. DECEDENT'S NAME (First, Middle, Last) Elizab	ath Ris	ick Gr	iffith				2. DATE OF DEATH	AY 10	YEAR 6:30 AM
	4. SOCIAL SECURITY NUMBER	5. SEX	_	s. lest birthday)	IF UNDER 1	VEAR F	UNDER 24 HRS.	7. DATE OF BIRTH	17	& BUSTHIN ACE (State or Engine
	142-12-3722	1 🗆 M 2 💢 💥	71	YRS.	MONTHS	DAYS HOL	URA MIN.	April 18	, 192	New Jersey
œ	9a. FACILITY NAME (If not institution, give at Dorchester Gener		+-1				OCATION OF DE	EATH		TY OF DEATN
1 6	RESIDENCE OF DECEDENT	gi noshi	Laı			Cambr	lage		שע	orchester
DIRECTOR	Maryland Dor	chester		10c. CIT	y, town on Cam	bridg	ge			10d. INSIDE CITY LIMITS? Y 1 YES 2 NO
ERAL	100. STREET AND NUMBER 705 Twin Point C	Cove Road				101. ZIP	CODE 21613		10g. CITIZ	EN OF WHAT COUNTRY?
BY FUNE	11. MARITAL STATUS 1 Never Married 2/ Married 3 Widowed 4 Divorced	12. WAS DECEDEN FORCES? IF YES, GIVE Y	NT EVER IN U.S. I YES X		H y	res, specify	ENT OF NISPAN Cuban, Maxica NO Specify	NC ORIGIN? (Specify Yen, Puerto Ricen, etc.)	s or No—	14. RACE — American indian, Black, White, etc. Specify: White
ETED	15. DECEDENT'S EDU((Specify only highest grade Elementary/Secondary (0-12)	CATION completed) College (1-4 or 5		Give kind of a	work done dur	UPATION ing most of i	working	16b. KIND OF BU	SINESS/INDU	JSTRY
once.	12	3		Regis	tered	Nurs	e	Health	n Care	9
# III	17. FATHER'S NAME (First, Middle, Lest) John Black							ME (First, Middle, Maiden .a Foracke)		
De notified TO BE	19a. INFORMANT'S NAME (Type/Print)	** 1 T						Route Number, City or Tow		
	Charles C. Griff	ith, Jr.						Rd. Cambri	-	
	1 A Buriel 2 Cremation 3 Remo	oval from State	20b. PLA cametery	CEANDDATE OF COMMENT O	ther place)	ON (Name of		1		ge, Maryland
examiner must	21. SIGNATURE OF AUNERAL SERVICE LIC	ENSEE	_ 0100	SII Law	22. NA	ME AND AD	ODRESS OF FA	CILITY		ge, naryrand
xami	· /// / - /	- 1-			Tho	omas 1	Funera.	1 Home, P.		
	23. PART/I. Enter the diseases, pro	complications the	t caused the	death, Do (700) Loci	ust St	. Cambridg	e, Ma	ryland 21613
event, the medical	IMMEDIATE CAUSE (Final Onset a									Interval Between Onset and Death
	Sequentially list conditions,	Diabel			/					3 days 15 years 30 years
or other traumatic	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE 70 (OR AS A CONSEQUENCE OF): 30									
L C C	PART II. Other algolificent condition	a contributing to	deeth but n	ot resulting	n the unde	riving car	use given in	Part I 24a WAS AN	AIITOPSV	24b. WERE AUTOPSY FINDINGS
shows any in: MEDICA	PART II. Other algorificent conditions contributing to deeth but not resulting in the underlying cause given in Part I. 1 24a, WAS AN AUTOPSY PRICE AUTOPSY FINE AMALABLE PRIOR TO COMPLETION OF CAL OF DEATH?							AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
	DID TOBACCO USE CONTR	RIBUTE TO CA	USE OF D	EATH YE	S IN	O U	INCERTAIN	10		1 YES 2 NO
ed, or item 23 s PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. P	LACE OF DEAT		/ one)				
YSI	t 🗆 YES 2 💢 NO	1 Inpatient 2		8 3 🗆 DOA	OTHER:	Nome 5	Residence	6 Other (Specify)		
marked, BY PH	27. MANNER OF DEATN 1 Natural 5 Pending 2 Newstigation	28a. DATE OF (Month, D	INJURY wy, Ybar)	28b. TIMI INJ	URY	WORK?		28d. DESCRIBE HOW I	NJURY OCCI	JRED
28 Is TED	2 Accident Investigation 3 Suicide 6 Could not be detarmined 28s. PLACE OF INJURY — At home, farm, streat, factory, office 28s. LOCATION (Street and Number or Rural Route Number, City or Town, State)						r Rural Route Number,			
MP AP	29e. CERTIFIER (Check only one) 1 X CERTIFYING PHYSIC one) 2 MEDICAL EXAMINER									d. cause(s) and manner as stated.
N C	296. BIGNATURE AND TITLE OF CERTIFIER									
듣 때	0 144527							D 14	9d. DATE SIGNED (Morith, Day, Year)	
E H	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)									
TO BE						v 57			MD	216/3

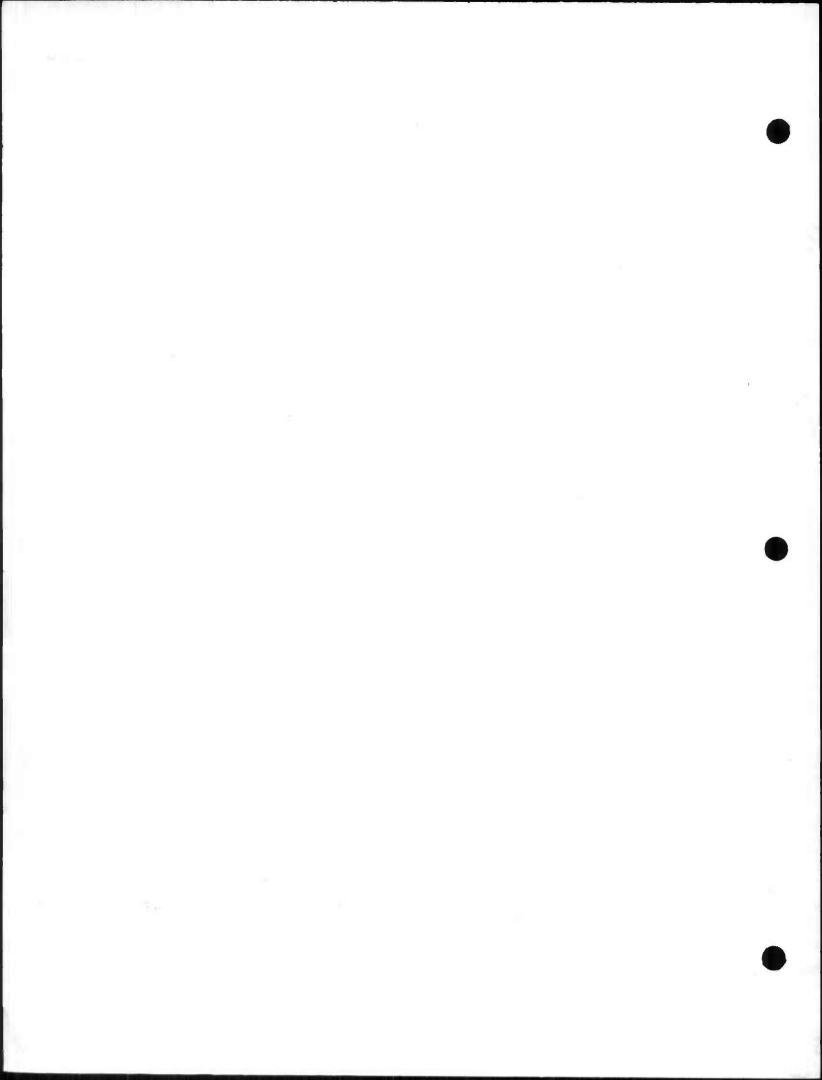


TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	: After this	be filed within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to bundl, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
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OR TATE	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL	HYGIENE
GISTRAR	CERTIFICATE OF DEATH	REG. NO.

	FOR STATE REGISTRAR	STATE OF MARY	LAND / DEPARTI CERTIFIC			ENTAL HYGIEN	E			
	1. DECEDENT'S NAME (First, Middle, Last FRANK BUR!		GRUWELL			2. DATE OF DEATH DA	26,19	VEAR	TIME OF DEATH 8:49 A M	
	4. SOCIAL SECURITY NUMBER 221-18-1809	1 🔀 M 2 🗆 F 6	6 YRS.	F UNDER 1 YEAR DNTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 8 - 2 - 1 9 2 9		Country) Dela	NCE (State or Foreign	
	98. FACILITY NAME (If not institution, given GIANT RD. & M. RESIDENCE OF DECEDENT		VIE DD		nd (rur		CECI	C OF DEAT	Н	
Sint	10e. STATE 10b. COU	w Castle		TOWN OR LOCAT				10d. INSIDE CITY LIMITS? 1 XYES 2 NO		
זענ	100. STREET AND NUMBER 341 Strawberi		•	101	2IP CODE 9709			N OF WHA	T COUNTRY?	
	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	13. WAS DEC		C ORIGIN? (Specify Yea , Puerto Rican, etc.)		USA or No- 14. RACE — American Indian, Black, White, atc. Specify: White				
LE I ED	15. DECEDENT'S E (Specify only highest gr Elementary/Secondary (0-12)	DUCATION ade completed) College (1-4 or 5 +)	16e. DECEDENT'S US (Give kind of wor life. Do NOT use in Truck	k done during mo retired.)	st of working	Transr		STRY	/Truckin	
	12 17. FATHER'S NAME (First, Middle, Last) Frank B. Gruv	vell, sr.	12401			E (First, Middle, Malden			, II denIII	
2	190. INFORMANT'S NAME (Type/Print) Anna Shahan		19b. MAILING A	Strawb	erry La	oute Number, City or Town ne, Middl	n. State, Zip C. etow:	n, D	e 19709	
	20a. METHOD OF DISPOSITION 1 X Burlel 2 Cremation 3 R 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE	emoval from State	ob. PLACEAND DATE OF ametary, crematory or othe Old Draw	P Place) Vers C 22. NAME AP	em. 10/	31/95 Od				
	Edwit C.A	1494	>	212	N. Broa	d st.,Mi	ddle		, De.	
	23. PART I. Enter the diseases, o shock, or heart failured immediate CAUSE (Finel disease or condition resulting in death)	re. List Drily Dna cause Dn s	aach line.			as cardiac or respi	retory sines	и,	Approximats interval Batween Onast and Dasth	
ILICATION	Sequentially list conditions, if any, isading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	с	A CONSEQUENCE OF):							
2	resulting in death) LAST	d								
MEDICAL	PART ii. Other significent condit	tions contributing to deeth	but not resulting in	tha underlyin	g cause given in i	Part i. 24a. WAS AN PERFOR	MED?	AV CC Of	ERE AUTOPSY FINDINGS MILABLE PRIOR TO DMPLETION OF CAUSE F DEATH?	
PITSICIAN: M	DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEATH	(Check only one)] UNCERTAIN				YES 2 NO	
Í	1X YES 2 NO	HOSPITAL: 1 Inpetient 2 ER/O	utpatient 3 DOA 4		se 5 Residence	Other (Specify) 28d, DESCRIBE HOW I		1050		
7 10	1 Netural 5 Pending 2 Accident Investigation	(Month, Day, Year	95 09-2	0 M 1 🕱	YES 2 NO	by mou	ver	-	njured	
	3 Suicide 6 Could not 4 Homicide determined	be building, atc. (S	1011	eet, factory, offic	•	261. LOCATION (Street I City or Town, State)	the R		Cecil Co.	
COMPLETED	CHOCK ONLY	IYSICIAN: To the best of my kn							nd manner as stated.	
	29b. SIGNATURE AND TITLE OF CERT	Glas			O.C.M.		POCT	SIGNED (M OBEF	Onth, Day, Year) 27,1995	
2	30. NAME AND ADDRESS OF PERSON	100001		nn Sti	ceet, Ba	ltimore,	Mar	ylar	nd 21201	
	31. DATE FILED (Month, Day, Year) OCT 3 0 1995	Julia Davidsor	Revolate						DMMM 48 Pay 4998	





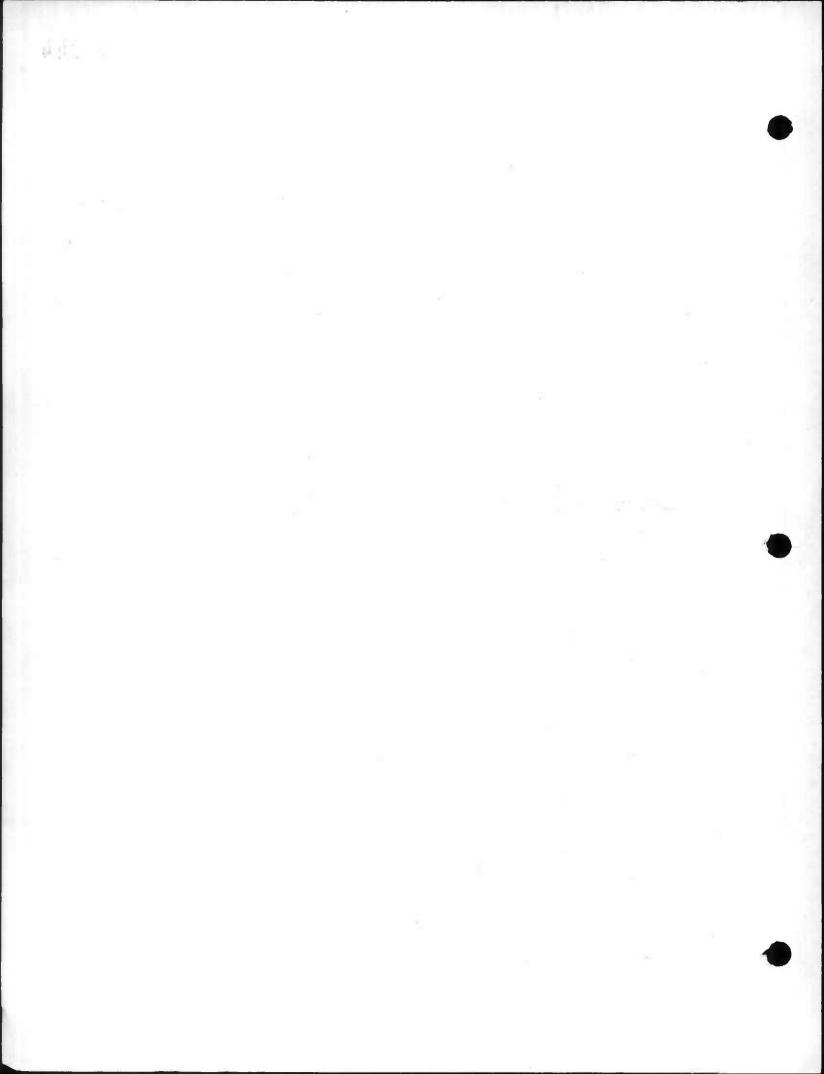
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<u>d</u>	death o
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ECC.	requires
AL	The law
DIVISION OF VITAL RECORDS, P.O. BOX 13146,	SPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within
/ISION	ATTENDING
6	YTAL OR
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NG PHYSICIAN: The law requires that the death certificate be executed within cours after death. Page 6 may be retained by the hospital or attending physician.	his certificate has been signed by the attending physician and completely filled In by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	MPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed to	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and com- be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, or	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic ev

1. DECEDENT'S NAME (First, Middle, Li				OAIL OI	DEATH	REG. NO			
	ETTIE	MARIE	GRI	EEN		2. DATE OF DEATH MONTH D. October 2		YEAR	TIME OF DEATH
4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. Is	-	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. OATE OF BIRTH			ACE (State or Foreign
192-14-9034	1 🗆 M 2 💢 F	72	YRS.	MONTHS DAYS	HOURS MIN.	June 23,	1923	Ohio	
Sa. FACILITY NAME (If not institution, g	ve street and number)	,		9b. CITY, TOWN	OR LOCATION OF I			TY OF DEA	
Northampton	Manor Nur	sing Ho	me	Fr	ederick		Fre	ederi	ck
RESIDENCE OF DECEDENT			10c. CITY.	TOWN OR LOCA	TION			1	Od. INSIDE CITY
Maryland	Frede				- 1	LIMITS? YES 2 NO			
Maryland Frederick Frederick 100. STREET AND NUMBER 100, ZIP CODE 100, CITIZEN OF V									
10006 Libe	rty Road				21701		Unit	ted S	tates
11. MARITAL STATUS	12. WAS DECEDEN FORCES? 1			13. WAS OF	CENDENT OF NISP	ANIC ORIGIN? (Specify Yes	or No-		- American Indian, White, etc.
1 Never Merried 2 Merried 3 Widowed 4 Divorced	IF YES, GIVE V		NO		NO Spec	can, Puerto Rican, etc.)		Specify:	White
15. DECEDENT'S	EDUCATION	140- 0	FORDERICO II						WIIILE
(Specify only highest g	rade completed)		Give kind of wo b. Do NOT use	SUAL OCCUPATI ork done during m retired.)	ost of working	18b, KINO OF BU	SINESS/IND	JSTRY	
Elementary/Secondary (0-12)	College (1-4 or 5	*1	Hor	nemaker		Own He	ome		
17. FATNER'S NAME (First, Middle, Last,					18. MOTHER'S N	AME (First, Middle, Meiden	Surname)		
EARL	HENRY	HAL	L		TWYL	A	HO	YT	
19a. INFORMANT'S NAME (Type/Print)		1				I Route Number, City or Tow		Code)	
Connie Collif1	ower		11804	Darby	Rd./ Ne	w Market, l	Md.	21774	
20a. METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 1	Removal from State	nther t	daca)		metery, crematory or		CATION — C		
4 Donation 5 Other (Specify)		Moun	t Oliv	vet Cem			deric	k,Mar	yLand
21. SIGNATURE OF PUNERAL SERVICE	LICENSEE	4"		22, NAME A	NO ADDRESS OF F	Stauff	er Fu	neral	Home
Raymone	Date:	con				town Pike/			,Md.21702
23. PART I. Entire the diseases,	or complications the	at caused tha d	leath. Do no	ot antar tha m	ode of dying, su	ch as cardiac or resp	iratory arre	et,	Approximate
IMMEDIATE CAUSE (Final		300 311 43011 111							Onset and Deati
disease or condition resulting in daeth)					MITIC CA				~2 yy
	DUE TO	(OR AS A CONS	EOUENCE OF						0
Sequentially list conditions,	b. DUE TO	(OR AS A CONS	OUENCE OF						
If any, leading to immediata cause. Enter UNDERLYING		(en ron a conta		•					
CAUSE (Disease or Injury	C. DUE TO	(OR AS A CONS	EOUENCE OF)	*					
that initiated events									
that initiated events resulting in death) LAST	d						LAUTODOV	246 4	VERE AUTOPSY FINDINGS
resulting in death) LAST	tione contributing to	death but not	resulting le	the underlyle	o cause alves I	n Part 24- USD 41			MAILABLE PRIOR TO
PART II. Other significant cond			resulting In	the underlying	ng cause given i	PERFO	RMED?		
PART II. Other significant cond	COLON CA		resulting in	the underlying	ng cause given i		RMED?	C	COMPLETION OF CAUSE OF DEATH?
PART II. Other significant cond	ASCUD, HT		resulting in	the underlying	ng cause given i	PERFO	RMED?	C	COMPLETION OF CAUSE
PART II. Other significant cond	ASCUD, HT		resulting In		ng cause given i	PERFO	RMED?	C	COMPLETION OF CAUSE OF DEATH?
PART II. Other significant cond 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	ASCUD, HT	, ,		26. F OTHER:	LACE OF DEATH (PERFO	RMED?	C	COMPLETION OF CAUSE OF DEATH?
PART II. Other significant cond	ASCUD, HT A. F13 HOSPITAL: 1 Inpettent 2 268. DATE OF	ER/Outpetient	3 DOA 28b. TIME	26. F OTHER: FY Nursing Hor OF 28c, IN	PLACE OF DEATH (to the second	PERFO	AMED?	1	COMPLETION OF CAUSE OF DEATH?
PART II. Other significant cond 25. WAS CASE REFERRED TO MEDICA EXAMINER? 1 YES 2 NO 27. MANNER OF DEATN Maturel 5 Pending	ASCUD, HT A. F13 HOSPITAL: 1 Inpettent 2 26e. DATE OF (Morth, L)	□ ER/Outpetient	3 🗆 DOA	26. F OTHER: 450 Nursing Ho OF 28c. IN W	PLACE OF DEATH (t	PERFO 1 YES : Check only one) 6 Other (Specify)	AMED?	1	COMPLETION OF CAUSE OF DEATH?
PART II. Other significant cond 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATN Matural 5 Pending Investigat 1 Accident 3 Suicide 6 Could not	ASCVD, HT A. F13 L HOSPITAL: 1 Inpetient 2 26a. DATE Of (Morth, L) (Morth, L) 28b. PLACE O Building	ER/Outpetient FINJURY Day, Year) OF INJURY — At 1	3 DOA 28b. TIME	26. F OTHER: 450 Nursing Ho OF 28c. IN	PLACE OF DEATH (to the state of	PERFO 1 YES: Check only one) 6 Other (Specify) 28d. DESCRIBE NOW 281. LOCATION (Street	RMED? 2 KNO INJURY OCC and Number	URED CO	OMPLETION OF CAUSE OF DEATH? YES 2 NO
PART II. Other significant cond 25. WAS CASE REFERRED TO MEDICA EXAMINER? 1 YES 2 NO 27. MANNER OF DEATN Matural 5 Pending Investigat 1 Accident	ASCVD, HT A. F13 L HOSPITAL: 1 Inpetient 2 26a. DATE Of (Morth, L) (Morth, L) 28b. PLACE O Building	ER/Outpetient F INJURY Day, Year)	3 DOA 28b. TIME	26. F OTHER: 450 Nursing Ho OF 28c. IN	PLACE OF DEATH (to the state of	Check only one) Other (Specify) 28d. DESCRIBE NOW	RMED? 2 KNO INJURY OCC and Number	URED CO	OMPLETION OF CAUSE OF DEATH? YES 2 NO
PART II. Other significant cond 25. WAS CASE REFERRED TO MEDICA EXAMINER? 1 VES 2 NO 27. MANNER OF DEATN Matural 2 Accident 3 Suicide 4 Homicide 29a. CERTIFIER (Check only) 1 CERTIFVINO P	ASCVD, HT A. F13 HOSPITAL: 1 Impettent 2 26e. DATE OF (Morth, L) 28e. PLACE Of building,	ER/Outpetient FINJURY Ony, Year) OF INJURY — At I., atc. (Specify)	3 DOA 28b. TIME INJU	26. FOTHER: 450 Nursing Hoto OF 28c. III W 1 □ reet, factory, offi	PLACE OF DEATH (Come 5 Realdence of the Come of the	PERFO 1 YES: Check only one) 6 Other (Specify) 28d. DESCRIBE NOW 281. LOCATION (Street	INJURY OCC	URED Or Rural Roo	OMPLETION OF CAUSE OF DEATH? YES 2 NO
PART II. Other significant cond 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATN Matural 5 Pending 1 Accident 3 Suicide 6 Could not detarmine 4 Homicide CERTIFYINO P. CERTIFIER (Check only)	ASCVD, HT A. F1S HOSPITAL: 1 Inpettent 2 26e. DATE OF (Morth, L) be duliding, d	ER/Outpetient F INJURY Day, Year) OF INJURY — At I , atc. (Specify) If my knowledge, of	3 DOA 28b. TIME INJU	26. FOTNER: 450 Nursing Hoto OF 28c, III W W 1 □ reet, factory, offi	PLACE OF DEATH (Come 5 Residence of the company o	PERFO 1 YES: Check only one) 6 Other (Specify) 28d. DESCRIBE NOW City or Rown, Stells	INJURY OCC	URED or Rural Acc	OMPLETION OF CAUSE OF DEATH? YES 2 NO
PART II. Other significant cond 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATN Matural 5 Pending 1 Accident 3 Suicide 6 Could not detarmine 4 Homicide CERTIFYINO P. CERTIFIER (Check only)	ASCUD HT A. F13 L HOSPITAL: 1 Inpetient 2 26e, DATE Of (Month, L) do 28e. PLACE C building, d HYSICIAN: To the best of MINER: On the besie of a	ER/Outpetient F INJURY Day, Year) OF INJURY — At I , atc. (Specify) If my knowledge, of	3 DOA 28b. TIME INJU	26. FOTNER: 450 Nursing Hoto OF 28c, III W W 1 □ reet, factory, offi	PLACE OF DEATH (Come 5 Residence of the company o	PERFO 1 YES Check only one) 9 6 Other (Specify) 2ed. DESCRIBE NOW 2ef. LOCATION (Street City or Rown, State use to the cause(a) and mane time, date and place, a	INJURY OCC	URED Or Rural Root or Rural Root e cause(a) 4	OMPLETION OF CAUSE OF DEATH? YES 2 NO

12 . FRODORICA
32. RESISTRAND SIGNATURE
Julia d'Aurilian Rardall

31. DATE FILED (MORITI, Day, Year)
OCT 3 0 1995



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiens prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

1 - STATE

_	REGISTRAN			ENIT	ICAIE	UF	DEATH		REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)	ROBERT WI	LLIAM	GARI	ONER				DATE OF DEATH		YEAR 95	3. TIME OF DEATH 9:25 A
	4. SOCIAL SECURITY NUMBER		AGE (In yrs. In	st birthday)	IF UNDER 1	DAYS	IF UNDER 24 HRS.		DATE OF BIRTH (Month, Day, Year)		8. BIRTH	PLACE (State or Foreign
	217-10-9900	1X M 2 🗆 F	74	YRS.	WONTHS	UATS	HOURS MIN.		an.5, 19			
	9a. FACILITY NAME (If not institution, give	street and number)			9b. CITY, TOWN OR LOCATION OF DEATH 9c. 0					9c. CO	COUNTY OF DEATH	
DIRECTOR	1311-A. North	Market St.			Frederick Freder					ick		
5	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT	~										
	133.000.	10c. CIT	Y, TOWN OF							10d, INSIDE CITY LIMITS?		
									1)X YES 2 NO			
¥						101	ZIP CODE					HAT COUNTRY?
FUNERAL	1311-A. North						21701				ted S	States
5	11. MARITAL STATUS 1 Nover Married 2 Married	12. WAS DECEDENT F	VER IN U.S. AI	RMED NO	13. W	WAS DEC	ENDENT OF HISPA	NIC O	RIGIN? (Specify Yes	or No-	14. RACE Black	— American Indian, , White, etc.
B	3 Wildowed 4 Divorced	IF YES, GIVE WAR	OR DATES		1	☐ YES	2 NO Specif	ly:	, , , , , , , , , , , , , , , , , , , ,		Speci	
	15. DECEDENT'S EDU	l Navy	. W.W.	II	1			_				WILLE
COMPLETED	(Specify only highest grade	completed)	(0	ECEDENT'S live kind of v	vork done du	uring mo	St of working		16b. KIND OF BUS			
ا چ	Elementary/Secondary (0-12)	College (1-4 or 5 +)							U.S. Go			
M	1.2 17. FATHER'S NAME (First, Middle, Last)	4		Acc	count	ing			Dept. o		vy	
	, , , , , , , , , , , , , , , , , , , ,	77 0	4 DDMIN						First, Middle, Maiden			
BE	SAMUEL	F. G	ARDNER				SUS			R.	FOUT	
ဍ	19a. INFORMANT'S NAME (Type/Print)		19						Number, City or Town			
	GENE GARDNER			-				/	Frederi			
	20a. METHOD OF DISPOSITION 1 Surial 2 Cremation 3 Ram	noval from State	20b.PLACE cemetery, cre			TION (Na	me of	- 1			- City or To	
	【☐ Donation 8 ☐ Other (Specify)		MOUN	T OL	VET		ETERY		10-28 Fr	eder	ick,	faryland
	21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE			22. N	IAME AP	ID ADDRESS OF FA	CILIT	Stauff	er F	unera	1 Home
i	(Sachmann	19,10	2 000)	16	21	Onoggumt	011				Md.21702
N		DUE TO (OR	O SCL A			PAS	DIOVAS	СЦ	LAR D) I SE	ASE	Onset and Death YEARS
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	C	AS A CONSE									
	PART II. Other algnificent condition	na contributing to de	sth but not	resulting i	n the und	derlying	g ceuse given in	Part	I. 24a. WAS AN		24b.	WERE AUTOPSY FINDINGS
EDICAL									PERFOR			AVAILABLE PRIOR TO COMPLETION OF CAUSE
									1 Tes 2	M NO		OF DEATH?
Σ	DID TOBACCO USE CONT	RIBUTE TO CAUS	E OF DEA	TH YE	SIN	10 F	UNCERTAI	N IS	a l			1 YES 2 NO
٤I	25. WAS CASE REFERRED TO MEDICAL			CE OF DEAT			OTTOLKIAN	1 12	-			
ဒ္ဌ	EXAMINER?	HOSPITAL:	Mutnetlant 1	□ DOA	OTHER:		- M	• □				
PHYSICIAN:	27. MANNER OF DEATH	28a. DATE OF INJ		28b, TIMI	- Y	28c. INJ	e 5 KRasidence	7	Other (Specify)	LILIBY OF	CHBED	
	1 Natural 5 Pending	(Month, Day, 1			URY		RK?	200	. DEGOMBE NOW II		CONED	
⋒	2 Accident Investigation	28a. PLACE OF IN	LHIRY — At by	uma tarm a	tract tasto			204	LOCATION (Over-			
	3 Suicide 8 Could not be 4 Homicide determined	building, atc.	(Specify)	Aire, tarm, s	erret, tactor	ry, orne			LOCATION (Street a City or Town, State)	nd Numbe	or Hural H	oule Number,
COMPLET	29e, CERTIFIER 1 CERTIFYING PHYS											
ő	one) 2 MEDICAL EXAMINE	ER: On the basis of exam	ination and/or	Investigation	n, in my op	ilnion, d	eath occured at the	tima,	data and place, and	dua to t	he cause(s	and manner as stated,
W	296. SHONATURE AND TITLE OF CERTIFIE	Roberts					29c. LICENSE NUI		67			(Month, Day, Year) 26 1995
일	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUSE O	OF DEATH (ITE	M 27) (Type,	Print)							
	RRRROBER	15 MD 5	2 TH	o ma	5 J	OH	NSON .	DK	FRED	ERI	ck '	42 21702
	31. DATE FILED (Month, Day, Year) OCT 3 0 199	32. REGISTRAR'S		•	1							
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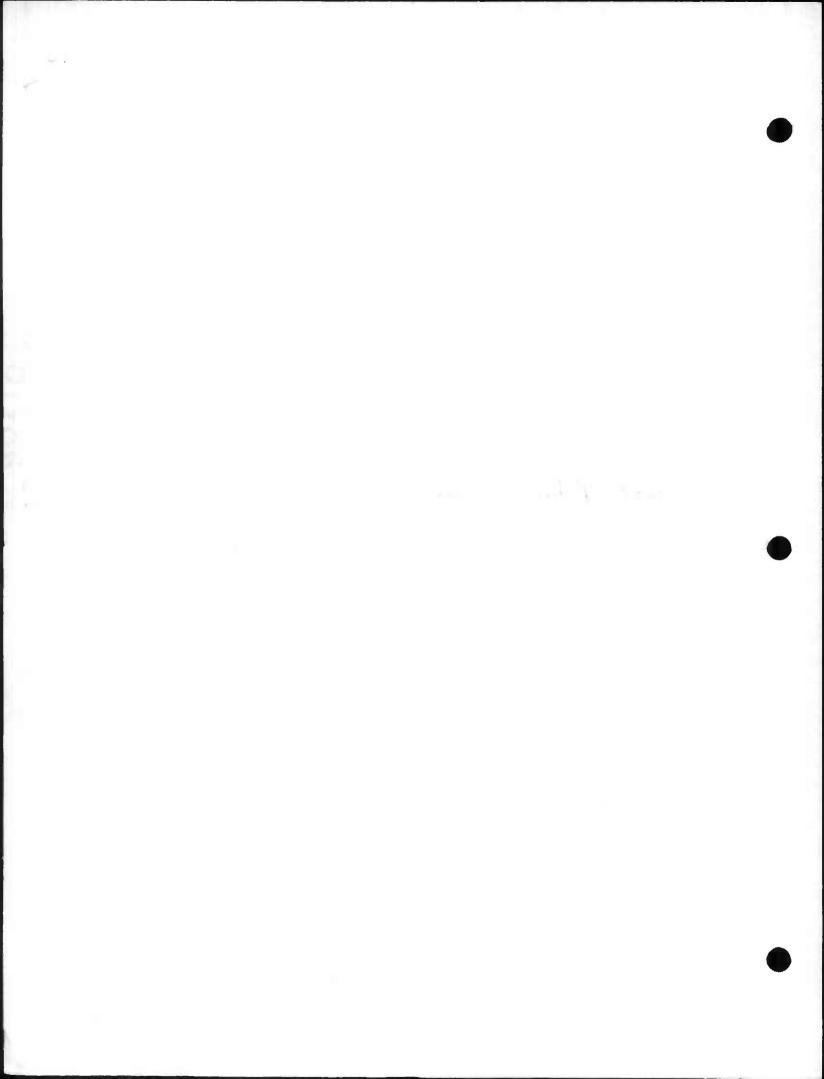
FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

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		1. DECEDENT'S NAME (First,	Middle, Last)								2. DATE OF				3. TIME OF DEATH
	- 4	Clifford Allen (October 23, 1995			95	2:52 pm M
		4. SOCIAL SECURITY NUMB		5. SEX		s. last birthday)	IF UNDER	DAYS	IF UNDER	_	7. DATE OF I	BIRTH K Verio	. /	S. BIRTH	IPLACE (State or Foreign
P										Vir	ginia				
3 should	g	99. FACILITY NAME (If not institution, give street and number) 90. CITY, TOWN OR LOCATION OF DEATH 90. COUNTY OF DEATH Frederick Frederick Frederick													
1, 2, 3	[[RESIDENCE OF DEC		ar Hospi	tar		FI	eaer	1.CK				Fr	eder.	ICK
Pages	DIRECTOR	10a. STATE	10b. COUNTY			10c. CI	TY, TOWN	OR LOCA	TION						10d, INSIDE CITY LIMITS?
		Maryland		derick		F	'rede	rick							1 X YES 2 NO
t perm	RAL	10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 21.701 I. C. A.													
the burial-transit permit.	FUNERAL	113 West South Street 21701 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Yes or No.— 14. RACE — American Indian.													
burial		1 Never Married 2		FORCES? 1	YES 2	NO		If yee, ap		an, Maxice	in, Puerto Rice		or No —	Black Speci	k, White, atc.
as the	ВУ	3 Widowed 4 1 Divo	rced	11 120, 0172	ON ONICE			1 1 163	24E NO	эрисп	у.			Speci	" White
use an	COMPLETED	15. DEC (Specify only	EDENT'S EDU	CATION completed)	164	Give kind of	work done	CCUPATI during me	ON ost of worki	ing	16b. KII	D OF BUS	SINESS/IN	DUSTRY	
	E	Elementary/Secondary (0	+)	Truck Driver						Mot	or F	reigl	ht.		
detached for once.	OM	8 Truck Driver Motor Freigh 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname)													
8 %	Ü	Coy	Elle	r	GR	EER				anni		DeFa		SI	NGLETON
5 should notified	10 B	19a. INFORMANT'S NAME (7	100								Route Number,				
page 5 s	F	Mrs. Dawn M. Cook 6161 Wellington Commons Dr, Alexandria, VA 22310													
tor, pa		20e. METHOD OF DISPOSIT	n 3 🗆 Fiam	ovel from State	20b. PL	ACE AND DATE	OF DISPO	SITION (N	ame of	- 26	,1995		CATION —		
funeral director, xaminer mus		4 Donation 5 Other 21. SIGNATURE OF FUNERA		DENGEE	Res	tnaver	22	NAME A	ND ADDRE	100 AE E4	CILITY				Maryland
uneral		Keeney & Basford P.A. Funeral Home 106 East Church Street, Frederick, MD 2170													
n by the f removal.	\vdash	75911	Lot	zen		M00706									
d in by or remo	П		esrt fellura.	List only one cer	use on each	line.	not ente	r tha me	oda of dy	ing, auc	ch as cardiac	or reapl	ratory ar	reat,	Approximata Intervsi Batween
y filled tion, o												Onset and Death			
completely fille ial, cremation, event, the		disease or condition resulting in death) a. Sepsis And Acute Re-altalure 24hr pue to lor as a consequence of: Sequentially list conditions. b. D. A setes Mellitas year											agh		
anding physician and completely filted in by the funeral director, programs prior to burial, cremation, or removal. or other traumatic event, the medical examiner must	z	Commentally lies and dis		b	ia	be t	ec.	1	211	+	15				Yen/1
ian ar	CERTIFICATION	Sequentially list conditions, lif any, leading to immediate cause. Enter UNDERLYING													
attending physician ntal Hygiene prior 1 y, or other trau	FIC	CAUSE (Disease or Injury that Initiated events DUE TO (OR AS A CONSEQUENCE OF):													
nding Hygie	E	resulting in death) LAST													
the aften Mental I		PART II. Other significent conditions contributing to deeth but not resulting in the underlying ceuse given in Pert I. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS													
y and	MEDICAL	0.1		- 1	1 6	L)	7 -	nderiyir	ig ceuse	given in		PERFOR	RMED?	246	AVAILABLE PRIOR TO COMPLETION OF CAUSE
signed Health a	E	of DEATH?													
S- 0 6		DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN											1 TES 2 NO		
e has te Dep m 23	I A	25. WAS CASE REFERRED T EXAMINER?				PLACE OF DE									
or item 23	PHYSICIAN:	1 YES 2 NO		HOSPITAL:	☐ ER/Outpatie	nt 3 🗆 DOA	4 Nu		ne 5 🗆 R	lesidence	8 🗆 Other (S	pecify)			
his ce with th	F	27. MANNER OF DEATH	Pending	28e. DATE Of (Month, I	F INJURY Day, Year)	28b. TI	ME OF	W	JURY AT ORK?		28d. DESCR	BE HOW I	NJURY OC	CURED	
After this death with	BY	2 Accident	Investigation	28e PLACE (OF INJURY —	At home form	etrant to		YES 2 [NO	284 I OCATI	DM /Stmat	and Abresho	a oa Grant I	Floute Number,
TOR: A after of 28 is	밀	3 Suicide 8 Homicide	Could not be determined	building	, etc. (Specify)	, , , , , , , , , , , , , , , , , , , ,	, 511001, 151	nory, on				own, Stete)		e or moral r	None Namos.
DIREC	E	29a. CERTIFIER	TIFYING PHYS	ICIAN: To the best o	f my knowledo	e death occur	red at the	time dat	e and place	and du	to the cause	a) and mar	oper en etc	ted	
FUNERAL within 72 TANT: II	COMPL	and -													s) and manner as stated.
TO THE FUNERAL DE filed within 72 h	Ö	296. SIGNATURE AND TITLE	о септи	н /	M				28c. LJC	ENSE NU	мвен		29d. DA	TE SIGNED	2 (Month, Day, West)
MPO THE	BE	()	DA	un y	-/X	in	2	-	N	1642	28		▶0	ct 2	4,1995
	임	30. NAME AND ADDRESS O	F PERSON W				e Timt)	_)						
		Casper E.		e, III	, M.D	., 30	O We	st	Nin	th S	St, F	rede	ric	k, M	1D 21701
		31. DATE FILED (Month, Day.		32. REGISTA	AR'S GIGNATU	P									
		0012	בבבו ה	. 0	- MORROW	artall									DHMH-16 Rev 1/89

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

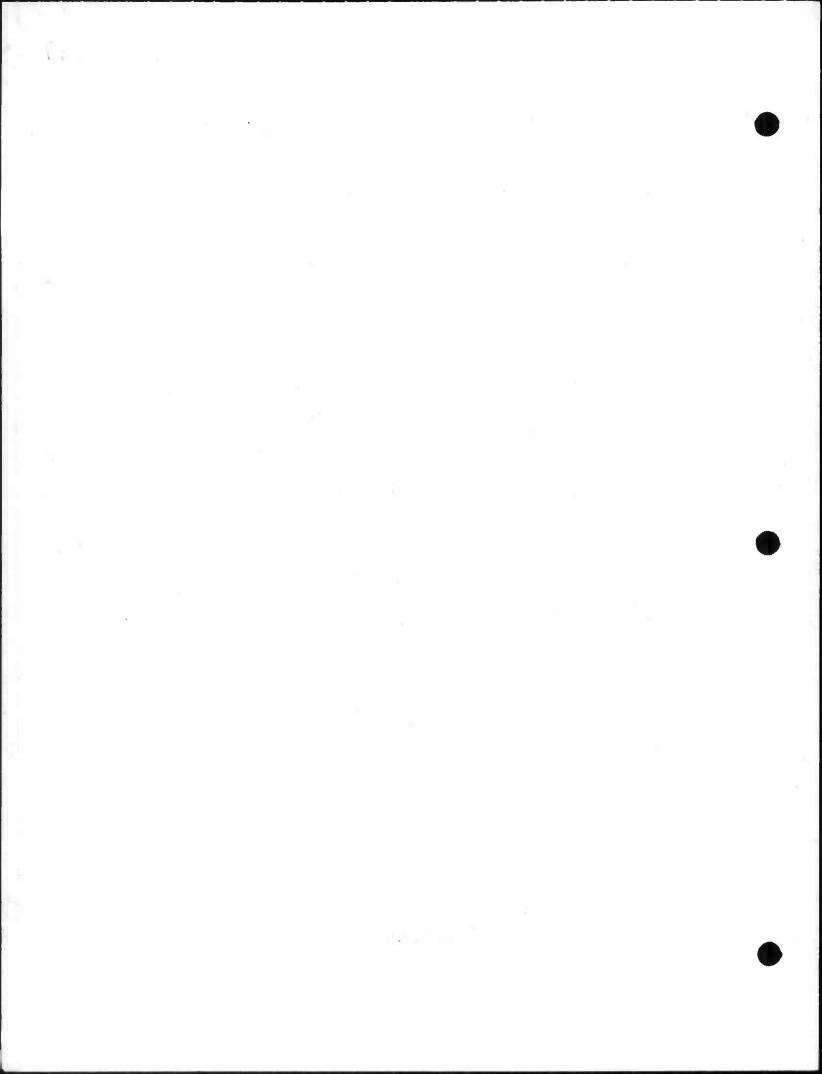


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ed withings hours after death. Page 6 may be retained by the hospital or attending physician.	this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Place 1, 2, 3 should	smation, or removal.	or item 23 shows any injury or other traumatic event the medical examinar must be notified at ence.
HE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed	DIRECTOR: After this certificate has been signed by the attending physician and com-	rs after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or ri	POBTANT: if item 28 is marked, or item 23 shows any injury, or other traumatic en
O THE HOSPITAL OR	THE FUNERAL DIREC	filed within 72 hours after death with	MPORTANT: If iten

1 - FOR BEGISTEAD STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		U	ERIT	ICAIL	UF	DEATH		REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last) Peter Norman GC)VE						MONTH	OF DEATH		YEAR	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. I	est hirthdey)	IF UNDER 1	VEAR	IF UNDER 24 HRS.	7. DATE C	ber 2!	, 19	995	11:44 P M HPLACE (State or Foreign
	086-36-3581	1 🔀 M 2 🗆 F	49	YRS.		DAYS	HOURS MIN.	(Month,	Day, Year)	1016	Count	try)
	9a. FACILITY NAME (If not institution, give s	treet and number)	47		95 CITY	TOWN C	P I OCATION OF D		er 25,			
r		Doctors' Community Hospital					96. CITY, TOWN OR LOCATION OF DEATH Lanham PRINCE GE					
DIRECTOR	RESIDENCE OF DECEDENT	ty Hospit	aı		Lan	ham				PICIT	vcG (GEORGE 3
Ĵ.	10e. STATE 10b. COUNTY	r		10c. CIT	Y, TOWN OF	LOCAT	ION					10d. INSIDE CITY
5	Virginia N/A			Ale	exand	ria						LIMITS?
	10e. STREET AND NUMBER			1111	-mana	_	ZIP CODE			10a, CIT	IZEN OF	WHAT COUNTRY?
FUNEHAL	101 N Ripley Stre	et. Ant.	103			,	22304				5.A.	
	11. MARITAL STATUS	12. WAS DECEDEN		RMED	13. W	_	ENDENT OF HISPA	NIC ORIGINS	(Specify Yea			F _ American Indian
	1 Never Married 2 Married	FORCES? 1 IF YES, GIVE W	YES 2 AR OR DATES]NO	14	yes, sp	2 NO Specific	an, Puarlo R				E — American Indian, ik, White, atc.
0	3 Widowed 4 Divorced		011 021 00		- 1	163	2 (A NO Specie	y.			Spec	White
5	15. DECEDENT'S EDUC (Specify only highest grade	CATION COMPOSITE OF THE PROPERTY OF THE PROPER		ECEDENT'S				16b.	KIND OF BUS	INESS/IN	DUSTRY	,,,,,
COMPLEIED	Elementary/Secondary (0-12)	College (1-4 or 5+		'Give kind of v fe. Do NOT us	vork done di se retired.)	unng mo	st of working					
Ĭ	12		Se	rvice	Tecl	hnid	cian		A.T. 8	T.		
5	17. FATHER'S NAME (First, Middle, Last)						18. MOTHER'S NA					
u	Carlton Gove						Margar	et	Wa	ignei	_	
20	19a. INFORMANT'S NAME (Type/Print)		1	9b. MAILING	ADDRESS	(Street a	nd Number or Rural					
-	Nancy Heintz											ia, VA 22304
	20a. METHOD OF DISPOSITION		20b. PLACI	E AND DATE (DE DISPOSIT	TION (No	me of	OATE	200 100	CATION	City or Tr	owo Stele
	1 Donation 5 Other (Specify)	oval from State	Metro	rematory or or	ther place)	rem.	atory 10	1/27/9	5 410	brev	ria	Virginia
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE		/	22. N	AME AN	D ADDRESS OF FA	ACILITY	J HIE	Aanu	ııa,	VIIGIIIIA
	De Colon Co	1 2	Ω	U	Fra	anci	s Gasch	's Son	ns Fur	era]	Hon	ne, P.A.
	cualles	T . 13k	W.	_	473	39 E	altimor	e Ave	Hyat	tsvi	11e.	MD 20781
	23. PART I. Enter tha diseases, or of shock, or heart feilure.	complications that List only one ceu	caused tha se on each iir	feath. Do r ne.	ot anter t	ha mo	da of dying, aud	ch aa cerdi	ec or respi	ratory ar	reat,	Approximats Interval Between
	IMMEDIATE CAUSE (Final Onset and Death											
	disease or condition resulting in death) s. GI Hemoriahage Due to (or as a consequence or):										5-64Rs	
	CHRONIC Alcoholism 20 yes											
ج ا												
CENTIFICATION	If sny, lasding to immediate	DUE TO	(OR AS A CONSEQUENCE OF):									
3	CAUSE (Disesse or Injury	с										
	that initiated events resulting in death) LAST	DUE TO	OR AS A CONS	EQUENCE OF	7):							
5	Total ting in death) EAST	d										
1	PART II. Other significant condition	a contributing to	daath but not	rasulting	n tha und	lerivino	ceuse given in	Part I.	24a, WAS AN	AUTOPSV	241	. WERE AUTOPSY FINDINGS
5	SEDS1C					,,,,,	gitter in		PERFOR	MEO?		AVAILABLE PRIOR TO COMPLETION OF CAUSE
5	30,013							-	1 YES 2	NO NO		OF DEATH?
2	DID TORACCO LIST CONTENT	DIDLITE TO CAL	ICE OF DE	A			·					1 TYES 2 NO
	DID TOBACCO USE CONTE	KIBUTE TO CA					UNCERTAI	ΝШ				
2	EXAMINER?	HOSPITAL:		ICE OF DEAT	OTHER:							
THI SICIAN.	1 X YES 2 NO	1 - Inpetiant 2			4 - Nursi	ng Hom	5 Residence	8 🗆 Other	(Specify)			
	27. MANNER OF DEATH 1 Netural 5 Pending	28a. DATE OF (Month, Da		26b. TIM	URY	WO		28d. DE\$0	RIBE HOW II	JURY OC	CURED	
5	2 Accident Investigation				M		ES 2 NO					
	3 Suicide 8 Could not be	28a. PLACE Of building,	INJURY — At h	iome, farm, s	treet, factor	ry, office		28f. LOCA City or	TION (Street a Town, State)	nd Numbe	r or Rural i	Route Number,
	4 Homicide determined											
	29a. CERTIFIER (Check only 1 CERTIFYING PHYSIC	CIAN: To the best of	my knowledge, o	leath occurre	d at the tim	ne, data	and place, and due	to the caus	e(a) and men	ner aa ata	ted.	
COMPLE	one) 2 MEDICAL EXAMINE											a) and manner as stated,
	296. SIGNATURE AND TITLE OF CERTIFIER						29c. LICENSE NUI		1			(Month, Day, Year)
4	JBayer MD						D259	25		D /	oto	bon 76/95
2	30. NAME AND AGORESS OF PERSON WHO	O COMPLETED CAUS	E OF DEATH (IT	EM 27) (Type.	Print)				ı	-	O1 0	100000
		#205,	1720	WISC	ONS	110	Ave E	BeThe	sele.	Md	73	hen 26/95
	31. DATE FILED (Month, Day, Year)	I 32. RIFGISTRAI	S SIGNATURE	Parl W						1200		
	OCT 27 1995	James	ATTEMPOR'S	ALC: NO.								



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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retain	TO THE RUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 sho	
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27	JII /	fion
within	npleteh	mention 79 hours after death with the State Dept of Health and Mental Hydiene orion to burial. Cremation, or removal
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	FOR 1 - STATE REGISTRAR	STATE OF I	MARYLAND /		RTMENT				MENTA	L HYGIEN	E		
	1. DECEDENT'S NAME (First, Middle, Last)									OF DEATN			TIME OF DEATN
	ARTHUR WOO	DROW	ROW GRAY Jr.						OCT			995	6:46 P M
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. las		IF UNDER	YEAR	IF UNDE	R 24 HRS.	7. DATE	OF BIRTH	1		NCE (State or Foreign
	579-42-7999	1 V M 2 - F	62	YRS.	MONTHS DAYS HOURS MIN.					n, Day, Year)	1022	Country)	
	90. FACILITY NAME (If not institution, give		April 22,1933 Washingto										
DIRECTOR	PRINCE GEORGES	PRINCE GEORGES HOSPITAL CEN					PRINCE GEO						
5	RESIDENCE OF DECEDENT 10a, STATE 10b, COUNT	~		10- 013	Y, TOWN O	010017	1011						
麗	District of Col			10c. Cr1								d. INSIDE CITY LIMITS?	
		umbra			was	nin	gton					1	X YES 2 NO
₹	10e. STREET AND NUMBER					101	ZIP COD			12000	10g. CITI	ZEN OF WHA	T COUNTRY?
FUNERAL	2430 Otis Stre	et, N. E	•				200	18			Unit	ed St	ates
5	11. MARITAL STATUS	12. WAS DECEDER	NT EVER IN U.S. AR	IMED						17 (Specify Yes	or No		American Indian,
	1 Never Married 2 Married	IF YES, GIVE	NAR OR DATES	NO				en, Mexica Specif		Rican, etc.)		Black, W Specify:	
BY	3 Widowed 4XXDivorced	Aug. 195	1/ Aug. 1	1971			1111						Black
	15. DECEDENT'S EDU (Specify only highest grad	JCATION	16a. DE	CEDENT'S	USUAL OC	CUPATIO	N of worth		168	. KIND OF BUS	SINESS/IND	USTRY	
	Elementary/Secondary (0-12)	College (1-4 or 5	H10.	. Do NOT u	se retired.)	-		-		Harris	J 11- 1		
그로	12th grade		Ret	ired	/Mili	tar	Fn	ator	ed III	Howar	d Uni	versi	ty & Force
COMPLETED	17. FATHER'S NAME (First, Middle, Last)		INCC	1100		car				Middle, Maiden		2 111	TOICE
e o		odrow	Gra	V	Sr.			ertr		Charles - Francis		Too	mer
BE		-				(Charle			_	has City as Tour	o Chata Tio		
TO B	196. INFORMANT S NAME (Typer-till)												
90	Jean-Francois Gray (son) 1804 Mt.Pisgah Lane, Apt. 32; Silver Spring, Maryland 20a. METNOD OF DISPOSITION 10 Burlet 2 Cremetton 3 Removal Irom State 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cremetory or other place). 20c. LOCATION — City or Town, State												
examiner must	20s. METNOD OF DISPOSITION 1 M Burlet 2 Cremation 3 Ren 4 Donation 5 Other (Specify)	noval Irom State	cemetery, cre	and date ematory or o g ton	Nati	ona	1 Ce	mete	ry	Arī	ingto	on, Vi	rginia
5	21. SIGNATURE OF FUNERAL SERVICE C	CENSEE)		22. P	NAME A	ID ADDRE	SS OF FA	CILITY	Latney	's Fi	ineral	Home
E	Mala VA	1001	L. Onme	2-1									
62	23. PART I. Enter the diseases, or confejications that caused the desth. Do not enter the mode of dying, such as cerdisc or respiratory streat, Approximate												
Vent, the medic	23. PART I. Enter the diseases, or configications that caused the death. Do not enter the mode of dying, such as cerdisc or respiratory arrest, ahock, or heart fellure. List only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) DUE TO (OR AS A DONSEOUENCE OFF.)												
2 7													
CERTIFICATION	Sequentielly list conditions, If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):												
A lag	csuse. Enter UNDERLYING												
TIFIC	CAUSE (Disease or injury thet initieted events	DUE TO	OR AS A CONSE	OUENCE C	OF):	-							
E	resulting in deeth) LAST												
e H		d											
를 그	PART II. Other significent condition	ne contributing to	death but not	resulting	in the un	deriyin	ceuse	given in	Part i.	24s. WAS AN			FRE AUTOPSY FINDINGS
PHYSICIAN: MEDICA										1 VYES 2			AILABLE PRIOR TO IMPLETION DF CAUSE
E E										1 19 165 2	□ NO		DEATH?
shows any : MEDIC	DID TORACCO LIST COAR	DIDLITE TO C	NUCE OF DEA	THE W	rc 🖂 N	IO E	VIII	CEDTAL	NI I			1	TES 2 NO
N N	DID TOBACCO USE CONT	KIBUTE TO CA					1 UN	CERTAI	ΝЦ				
티궁	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLA	CE OF DEA	OTHER								
YSICI,	XXES 2 □ NO	1 Inpetient 2	ER/Outpatient 3	DOA			6 5 E	lesidenca	8 🗆 Oth	er (Specify)			
등	27. MANNER OF DEATH	28a. DATE O	F INJURY Day, Year)	28b. TH	WE OF	28c. INJ	URY AT		28d. DE	SCRIBE HOW I	NJURY OC	CURED	
marked, BY PH	1 Netural 5 Pending 2 Accident Investigation	10/22	195		9 pM	1 🗆	YES 2	NO	moto	- vehicl	e coll	ision	
	3 Suicide 8 Could not be		OF INJURY - At he	oma, ferm,	atreal, facto	ory, offic	•		281. LO	ATION (Street	and Number	or Rural Rout	e Number, -
Z8 IS	4 Homicide determined	building	, etc. (Specify)	tree	+						Martin	Luther	King Highway
E W	29a. CERTIFIER									indover.	Ma		
COMPLETED	(Check only one) 2 MEDICAL EXAMIN												nd manner as stated.
	29b. SIGNATURE AND TITLE OF CERTIFIE	P A A					29c. LIC	ENSE NU	MBER		29d. DAT	E SIGNED (M	onth, Day, Year)
BE	()	1. 11.1					0	.C.1	M.E		Poc	ר . ידי	3,1995
일	30. NAME AND ADDRESS OF PERSON W	HD COMPLETED CAL	JSE OF DEATH (ITE	M 27) (7/n	e, Print)						00	J 1 0 C	011773
	DEMAIS CHUTE		111	. Pe	nn S	tre	et,	Ba.	ltim	ore,	Mary	land	21201

32. BEGSTRAT'S SIGNATURE

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Z4 hours after death. Page 6 may be retained by the hospital or attending physician.	To this control, and the State Dept. of Health and Merital Hygiene prior to builds, cremation, or removal. We find within 72 hours after death with the State Dept. of Health and Merital Hygiene prior to builds, cremation, or removal. IMPORTANT: If them 28 is marked, or them 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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	1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPARTI	MENT OF H	EALTH AND	MENTAL HYGIEN							
	1. DECEDENT'S NAME (First, Middle, Lest) Emma Mae (Glispery				2. DATE OF DEATH OCTOBER 2		3. TIME OF DEATH 3: 15P					
				F UNDER 1 YEAR DAYS	IF UNDER 24 HRS. HOURS MHI.	7. DATE OF BIRTH (Month, Day, Year) 5-16-2	8. 1	BIRTHPLACE (State or Foreign Country) [ASH.D.C.					
_	9e. FACILITY NAME (If not institution, give stre		9	b. CITY, TOWN O	R LOCATION OF 0		9c. COUNTY						
TOF.	DOCTORS HOSPIT	ral	I	LANAHA	.M		Mont	ogomery					
DIRECTOR	d . C .			TOWN OR LOCAT		10d. INSIDE CITY LIMITS? XXYES 2 \(\text{N} \) NO							
IAL	10e. STREET AND NUMBER			101.	ZIP CODE		OF WHAT COUNTRY?						
FUNERAL	1372 VAN BUREN				20011			.S.A.					
ВҰ	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Never Merried 4 Divorced	12. WAS DECEDENT EVER IF FORCES? 1 YES IF YES, GIVE WAR DR DA	2)(7)(90	13. WAS DEC	cify Cuban, Mexico	NIC ORIGIN? (Specify Year, Puerto Ricen, etc.) y:		RACE — American Indian, Black, White, atc. Specify; BLACK					
9	15. DECEOENT'S EDUCA (Specify only highest grade of	TION ompleted)	16a. DECEDENT'S US	UAL OCCUPATIO	IN st of working	16b. KINO OF BU							
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+) 3yrs	(Give kind of work life. Do NOT use n		of or working	PR	IVATE						
OMI	17. FATHER'S NAME (First, Middle, Lest)	Sumame)											
BE C	OLIVER CLARK					JANE ESKI							
TO B	19e. INFORMANT'S NAME (Type/Print)				nd Number or Aural	Route Number, City or Tox	vn, State, Zip Cod						
	DORIS TAYLOR 7216 TRESCOTT AVE. TACOMA PARK MD. 2												
	20b. PLACE AND DATE OF DISPOSITION 1 State 20b. PLACE AND DATE OF DISPOSITION (Name of cemeter), cremetory or other place) 4 Donation 5 Other (Specify) 1 0 / 28 T AND OVER MD												
	21. SIGNAYOR OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY												
	Khames 1	Villen					AMS						
	23. PART I. Enter the diseases, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, ahock, or heart failure. List only one ceuse on each line. Approximate interval Batween												
	immediate Cause (Final disease or condition resulting in death) Intracerebellar Hemorrhage												
	a.		CONSEQUENCE OF):										
NO	Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST Respiratory Failure DUE TO (DR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE DF):												
ATI													
CERTIFICATION													
	PART II. Other aignificent conditions	contributing to death b	ut not regulting in t	he underlying	serves alves le	Book I as union							
PHYSICIAN: MEDICAL	Hypertension, Da	iabete Melli	tus		Cause given in	Part I. 24s. WAS AN PERFO	RMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?					
× :	DID TOBACCO USE CONTRI	BUTE TO CAUSE O	F DEATH YES	Пиоп	LINCEPTAL	N IXI		1 YES 2 NO					
Ä	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEATH		OTTCERTAIN	1							
YSIC	1 TYES 2 XNO	OSPITAL:		THER: Nursing Home	5 Reeldence	6 Other (Specify)							
	27. MANNER OF OEATH 1 Netural 5 Pending	26e. DATE OF INJURY (Month, Day, Year)	28b. TIME O	Y WOF	PK?	26d. DESCRIBE HOW	NJURY OCCURE	D					
BY	2 Accident Investigation	26e. PLACE OF INJURY	— At home form etra-		ES 2 ND	201 LOCATION (DI							
回	3 Suicide 4 Homicide Could not be determined 26e. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) 26f. LOCATION (Street and Number or Rural Roucity or Town, State)												
COMPLETED	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIA 2 MEDICAL EXAMINER:	AN: To the bast of my knowl On the basic of examination	edge, death occurred a	n my opinion, de	end place, end due	to the cause(e) end ma time, date and place, er	nner se stated,	rse(s) end menner se stated.					
BE	29b. SIGNATURE AND TITLE OF CERTIFIER	m TAL)			29c. LICENSE NUI			NED (Month, Day, Year)					
2	30. NAME AND ADDRESS OF PERSON WHO CO	COMPLETED CAUSE OF DEL	e Point D	rive, G	Greenbel	t, MD 207	70	~7/13					
	31. DATE FILED (Month, Day, Year) OCT 26 1995	32. RESISTRANIS SIGNA	ATURE RENTALL										

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DIVISION OF VITAL I	I

	1 - STATE REGISTRAR	STATE OF I		/ DEPAI CERTIF					ENTAL HYGIEN REG. NO					
	1. DECEDENT'S NAME (First, Middle, Las	SUSIE	ESTELL	E HOLI	LIDAY			2	DATE OF DEATH	5 19	YEAR S	3. TIME OF DEATH		
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs.		IF UNDER	1 YEAR DAYS	IF UNDER 24	4 HRS. 7	DATE OF BIRTH		BIOTHE	LACE (State or Foreign		
	217-10-8656 9a. FACILITY NAME (If not institution, give	1 🗆 M 2 💢 🤆 F	82	YRS.					Aug 17,19			Maryland		
OR	Dorchester Gene		tal		96. CITY		mbrid		Н	9c. COUNT	rche.			
5	RESIDENCE OF DECEDENT 10a. STATE 10b. COUN	- December 1												
DIRECTOR	Maryland	Dorchest		Camb					10d. INSIDE CITY LIMITS? YES 2 NO					
FUNERAL	10. STREET AND NUMBER 2609 Brian Circ	le				N OF WH	AT COUNTRY?							
ā	11. MARITAL STATUS 1 Never Merried 2 Married 3 Widowed 4 Divorced	Never Merried 2 Married FORCES? 1 YES 2 X						II. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Year of If yea, specify, Cuban, Mexicen, Puerto Rican, etc.) 1 YES A N O Specify:						
COMPLEIED	15. DECEDENT'S EL (Specify only highest gra Elementary/Secondary (0-12)	(Give kind of life. Do NOT u	3ive kind of work done during most of working Do NOT use retired.)						Publishing Co.					
	17. FATHER'S NAME (First, Middle, Last) Charles Goldsbo			16. MOTHER'S NAME (First, Middle, Melden Surneme) Elsie Insley										
IO BE	190. INFORMANT'S NAME (Type/Print) E. Diane Glover 190. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2609 Brian Circle Cambridge, Maryland 21613													
	20b. PLACE AND DATE OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of Commetter), prematory or other place) Date 20c. LOCATION - City or Town, State Dorchester Memorial Park 10/28 Cambridge, Maryland													
	22. NAME AND ADDRESS OF FACILITY Thomas Funeral Home, P.A. 700 Locust St. Cambridge, Maryland 2161													
	23. PARTY. Enter the diseases, or complications that caused the desth. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heart fellure. List only one cause on sech line. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF):											Approximate Interval Between Onset and Death		
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST													
MEDICAL CER	PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Neutro pency Performed? 1 yes 2 no of Deat									FERE AUTOPSY FINDINGS WAILABLE PRIOR TO OMPLETION OF CAUSE F DEATHY YES 2 NO				
	DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL	TRIBUTE TO CA		ATH YE			UNCE	RTAIN						
SICI	EXAMINER? 1 YES 2 NO	HOSPITAL:			OTHER	1:	a & 🗆 Beate	danaa 8 [Other (Specify)					
PHYSICIAN:	27. MANNER OF DEATN 1 Netural 5 Pending	28a. DATE OF (Month, D	INJURY	28b. TIM		28c. INJI WO	URY AT RK?	21	Id. DESCRIBE NOW	NJURY OCCU	RED			
TED BY	2 Accident Investigation 3 Suicide 8 Could not b. 4 Homicide determined	28e. PLACE O	28e. PLACE OF INJURY — At home, term, street, factory, off building, etc. (Specify)				YES 2 NO 281. LOCATION (SI City or Town, S			reet and Number or Rural Route Number, State)				
COMPLET	290. CERTIFIER (Check only one) 1 CERTIFYING PHY 2 MEDICAL EXAMI	SICIAN: To the best of e										nd manner ee stated.		
O BE C	29b. SIGNATURE AND TITLE OF CENTIFI	nm			29c. LICENSE NUI							fonth, Day, Year)		
-	30. HAME AND ADDRESS OF PERSON W	HO COMPLETED CAU	SE OF DEATH (IT	TEM 27) (Type	Print)	~~	Cas	ton	١٥ ١٥	60/				
	31. DATE FILE ONCH 3 0 199	5 July a	R'S SIGNATURE	ardall										

BALTIMORE, MARYLAND 21215-0020	ath. Page 6 may be retained by the hospital or attending physicia	meral director, page 5 should be detached for use as the burial.
	Yours after dea	lled in by the fu
	Į,	ely fi
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	L OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within fours after death. Page 6 may be retained by the hospital or attending physicis	DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burnal-r
ISION	STITENDING	CTOR: After
2	. OR /	DIRE

the burlal-transit permit. Pages 1, 2, 3 should ding physician. TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. Nours after death, Page 6 may be retained by the hosp TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

	1 - FOR STATE REGISTRAR	STATE OF MARYLAN	D / DEPAR CERTIF	TMENT	OF H	EALTH	AND I		HYGIEN REG. NO				
	1. DECEDENT'S NAME (First, Middle, Last)							2. DATE OF				3. TIME OF DEATH	
	Mary	Ho1	lland					Octob		AY 5. 19	95	2:40	рм
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (In yr.	s. lest birthday)	IF UNDER		IF UNDER	24 HRS.	7. DATE OF	BIRTH	,	6. BIRTH	IPLACE (State or Form	
	217-76-9424	1 🗆 M 2 💢 F	33 YRS.	MONTHS	DAYS	HOURS	MIN.	Dec.		1911	Count	Maryland	
	9a. FACILITY NAME (If not institution, give street	et and number)		9b. CITY	TOWN C	R LOCATIO	ON OF DE			9c. COU			
OR	Solomons Nursing (Center		5	0101	nons				Ca	lve1	ct	
DIRECTOR	RESIDENCE OF DECEDENT 10a, STATE 10b, COUNTY						_						
E	N/A N/A		10c. CITY	r, TOWN C				_				10d, INSIDE CITY LIMITS?	
	10, STREET AND NUMBER	7		Was		gton,	_	C.				1 X YES 2 N	10
A		11001			101	ZIP CODE				2017		WHAT COUNTRY?	
FUNERAL	428 Ridge Road S. E					2001					SA		
3	1 Never Married 2 Married	12. WAS DECEDENT EVER IN U.S FORCES? 1 TYES 2	XNO					NC ORIGIN? (s or No—	14. RACE Black	E — American Indian k, White, atc.	١,
BY	3XXWidowed 4 Olvorced	IF YES, GIVE WAR OR DATES		'	YES	2 XNO	Specify	y:			Speci	w: Black	
8	15. DECEOENT'S EDUCA	TION 18r	. DECEOENT'S	USUAL O	CCUPATIO	N		16b, KI	ND OF BU	SINESS/IND	USTRY		
	(Specify only highest grade co	mpleted) College (1-4 or 5+)	(Give kind of w life. Do NOT us	rork done (e retired.)	during mo	st of workin	g	1.555					
AP.	11		Homema	ker				0	wn H	ome		15,000	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)					18. MOTH	IER'S NA	ME (First, Midd	dle, Maiden	Sumame)			
BE	Maurice Sewell	Brooks				Ag	nes		C	oates			
10	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING										
-	Queenie Smith		428 Ri	dge	Road	l S.E	#2	204 W	ashi	ngton	, D.	.C. 20019	
	20g. METHOD OF DISPOSITION 1X Burlel 2 Cremation 3 Remove	al from State 20b. PLA	CE AND DATE O		ITION (Na	me of		OATE	20c. LO	CATION —	City or To	wn, Stata	
1	4 Donation 5 Other (Specify)	Ho	11and	Ceme	tery	7	10					own, MD	
	21. SIGNATURE OF FUNERAL SERVICE LICEN	ISEE				O ADDRES		DE		Fune			
	Sparce	Some	00	14	51 I	ares	Bea	ach Rd	. Pr	ince	Fred	lerick, M	D
	23. PART I. Enter the diseases, or cor	mplications that caused the st only one cause on each	e death. Do n	ot enter	tha mo	de of dyl	ng, suci	h ee cerdiad	or respi	iratory arr	eat,	Approximat	
	IMMEDIATE CAUSE (Finel	only one cause on each	iina.									Interval Bat Onset and	
ĺ	disease or condition resulting in death)	arenna										Ini	reth
		OUE TO (OR AS A COL	NSEQUENCE OF):	1	.7	1			,	7		
Z	Sequentially list conditions, b.	Chronic	KL	na	l	Ja	ill	ire	u	ula	100	or yea	13
CERTIFICATION	If any, leeding to immediate ceuse. Enter UNDERLYING	OUE TO (OR AS A CO	NSEOUENCE OF):			1	"	,			/	
	CAUSE (Disease or injury that initiated events	DUE TO (OR AS A COR					Cu	use		-			
Ē	resulting in deeth) LAST	(0111011011		,-								j	
8	d.												
A I	PART II. Other aignificent conditions	contributing to deeth but n	not resulting i	n the un	derlying	ceuse g	iven in	Part I. 24	a. WAS AN		24b.	WERE AUTOPSY FINE	
음	organic Br	ain syn	aro	m				_ 1	YES 2	DENO		COMPLETION OF CA OF DEATH?	
ME	-											1 YES 2 NO	
PHYSICIAN: MEDIC	DID TOBACCO USE CONTRII	BUTE TO CAUSE OF D	EATH YE	S 🗆 1	10 B	UNC	ERTAIN	۷ 🗆					
<u>S</u>	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. F	PLACE OF OEAT	OTHER									
YS		☐ Inpatient 2 ☐ ER/Outpetien	_	4 Nun	ung Home	5 🗆 Ras	sidenca	8 Other (S	(pecify)				
ᆵ	27. MANNER OF DEATH 1 Natural 5 Pending	28a. OATE OF INJURY (Month, Day, Year)	28b. TIME		28c. INJI WO	RK?		28d. DESCR	IBE HOW I	NJURY OCC	URED		
B	Z Accident Investigation			М		ES 2	NO						
a	3 Suicide 8 Could not be 4 Homicide determined	28a. PLACE OF INJURY — A building, atc. (Specify)	u home, larm, s	treet, fact	ory, office	I			ON (Street a fown, State)		or Rural F	Route Number,	
COMPLETED	20. CERTIFIER												
M M	(Check only	AN: To the best of my knowledge											
8		On the besis of examination and	d/or investigation	n, In my o	pinion, de	eth occur	d at the	Ilme, data and	d placa, an	d due to the	cause(s) and manner as sta	ted.
H H	29b. SIGNATURE AND TITLE OF CERTIFIER	-1-	110			29c. LICE	NSE NUM	ABER 1		29d. DATE	SIGNEO	(Month, Day, Year)	
ᅙ	30. NAME AND ADDRESS OF PERSON WHO C	vuly !				D	カ り	131		- /	0/0	26/95	
	120 HOSDITO	COMPLETED CAUSE OF DEATH	Per (Type,	Print)	ed) . ,	111	0	21	267	R	-	
	31. DATE FILEO (Month, Day, Year	32: REGISTRAR'S SIGNATUR	E			-	V 1 4			- 00/	U		
	OCT 3 0 1995	Julia Davidson Re	ardall .										

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Item ő marked, BY 69

COMPLETED item 28

BE 2

use as the burial-transit permit. Pages 1, 2, 3 should

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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the deatl	y the att	d Menta	Injury,
s that the deatl	ned by the att	ith and Menta	any Injury,
equires that the deatl	en signed by the att	of Health and Menta	hows any Injury.
w requires that the deatl	been signed by the att	pt. of Health and Menta	3 shows any injury,
he law requires that the deatl	has been signed by the att	e Dept. of Health and Menta	m 23 shows any Injury,
AN: The law requires that the death	ificate has been signed by the att	: State Dept. of Health and Menta	r item 23 shows any Injury,
SICIAN: The law requires that the deatl	certificate has been signed by the att	I the State Dept. of Health and Menta	f, or item 23 shows any injury,
PHYSICIAN: The law requires that the deatl	r this certificate has been signed by the att	h with the State Dept. of Health and Menta	arked, or item 23 shows any Injury,
DING PHYSICIAN: The law requires that the deatl	After this certificate has been signed by the att	death with the State Dept. of Health and Menta	s marked, or item 23 shows any Injury,
TENDING PHYSICIAN: The law requires that the deati	TOR: After this certificate has been signed by the att	after death with the State Dept. of Health and Menta	28 is marked, or item 23 shows any Injury,
R ATTENDING PHYSICIAN: The law requires that the deatl	RECTOR: After this certificate has been signed by the att	urs after death with the State Dept. of Health and Menta	im 28 is marked, or item 23 shows any injury,
AL DR ATTENDING PHYSICIAN: The law requires that the deatl	L DIRECTOR: After this certificate has been signed by the att	2 hours after death with the State Dept. of Health and Menta	t item 28 is marked, or item 23 shows any injury,
SPITAL DR ATTENDING PHYSICIAN: The law requires that the deatl	IERAL DIRECTOR: After this certificate has been signed by the att	in 72 hours after death with the State Dept. of Health and Menta	IT: It item 28 is marked, or item 23 shows any Injury,
HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the deatl	FUNERAL DIRECTOR: After this certificate has been signed by the att	within 72 hours after death with the State Dept. of Health and Menta	ITANT: It item 28 is marked, or item 23 shows any Injury,
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospit	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached	filed within 72 hours after death with the State Dept. of Health and Menta	IMPORTANT: It liem 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 1995 HAWKINS OCTOBER 22 1:00 AM WILLIAM 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH 6. AGE (In yrs. last birthday) 8. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR | IF UNDER 24 HRS. Sept. 1, HOURS 218-52-6552 1 X M 2 | F 48 YRS Maryland 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATN Prince George's General Hospital DIRECTOR Cheverly Prince George's RESIDENCE OF DECEDENT 10a STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Prince George's Riverdale 1. YES 2 X NO FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 6269 64th Ave. Apt. 6 20737 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 AYES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married If yes, specify Cuban, Maxican, Puerto Rican, etc.)

1: YES 2 XNO Specify: Nov. 1966-Nov. 1972 Specify: Black BY 3 Widowed 4 Divorced COMPLETED 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) 12 Foreman Sanitation 17. FATNER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) Calvert Hawkins Eugene Mamie BE Jones 19a, INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Joseph Hawkins P.O. Box 58 Dunkirk, MD 20754 20s. METNOD OF DISPOSITION
12 Buriel 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE Moses Cemetery 10/27/95 Lothian, MD 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Sewell Funeral Home 1451 Dares Beach Rd. Prince Frederick, MD 23. PART I. Efter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or reapiratory arrest, Approximata Interval Between shock, or heart failure. List only one cause on each line. Onaet and Death IMMEDIATE CAUSE (Final disease or condition 9 mon ancerona resulting in death) DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentielly liet conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease Dr Injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in deeth) LAST PART II. Other aignificent conditions contributing to death but not resulting in the underlying ceuse given in Part I. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE 1 TES 2 XNO OF DEATN? 1 YES 2 NO PHYSICIAN:

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES
NO UNCERTAIN

5. WAS CASE REFERRED TO MEDICAL	26. PLACE OF DI	26. PLACE OF DEATN (Check only one)									
1 YES 2 NO	HØSPITAL: 1 Inpetient 2 ER/Outpatient 3 DOA	OTHER: 4 Nursing Nome 5 Rasidence	6 ☐ Other (Specify)								
7. MANNER OF DEATN 1 Natural 5 Pending 2 Accident Investigation		ME OF 28c, INJURY AT WORK? M 1 YES 2 NO	28d. DESCRIBE NOW INJURY OCCURED A,								
3 Suicida 8 Could not be 4 Homicide	28a. PLACE OF INJURY — At home, farm building, atc. (Specify)	n, atreet, factory, office	281. LOCATION (Street and Number or Rural Route Number, City or Town, State)								

29a. CERTIFIER 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

MEDICAL EXAMINER:	On the beals of	examination and/or	Investigation, Ir	my opinion,	death occured at I	the time, data a	nd place, an	d due to the	cause(s) and r	manner as stated.
05 440 777 5 05 0507777										

296. SIGNATURE AND TITLE OF CERTIFIER	29c, LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)

30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print) SURIAND 140

31. DATE FILED (Month, Day, Year)

OCT 27 32. REGISTRAR'S SIGNATURE

DNMH-16 Rev 1/89

The second secon 2 g 360 s NI V s NI V s

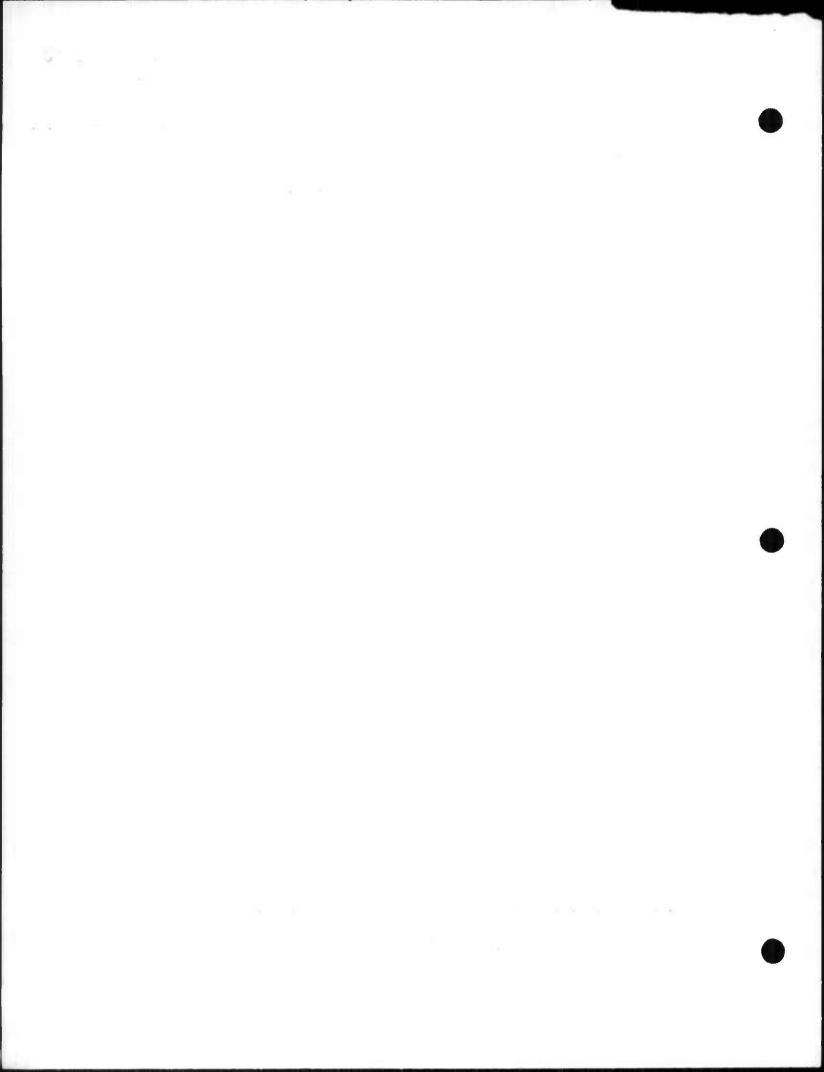
TO THE HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burla-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlai, certainon, or removal. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO.

_		REGISTRAR		C	ERTIF	ICATE (F DEATH		REG. NO.			
		1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF	DEATH			3. TIME OF DEATH
		Brownie Marie	Hines					OCTO	her	24, 1	995	7:25 A.M.
- 1		4. SOCIAL SECURITY NUMBER		(In com.)	last birthday)	IF UNDER 1 YE	AR IF UNDER 24 HRS.			7 7		
		218-34-2473		(in yrs.)	YRS.	MONTHS DA		7. DATE OF (Month, D	BIRTH by, Year)		Country)	LACE (State or Foreign
					YHS.			JAN/6/	32	1	Vest	Virginia
	_	9e, FACILITY NAME (If not institution, give a				96. CITY, TO	VN OR LOCATION OF D	EATH	-	9c. COUR	NTY OF DE	ATH
	CTOR	Laurelwood Nursi	ng Center			Elkto	n, Md. 21	921		Cec	<i>i1</i>	
- 13	ا ۃ	RESIDENCE OF DECEDENT										
	DIRE	10e. STATE 10b. COUNT				Y, TOWN OR LO					1	10d. INSIDE CITY LIMITS?
		Maryland Cec	11		1	Elktor	1				,	YES 2 NO
	4	10e. STREET AND NUMBER					10f. ZIP CODE			10g. CITI	ZEN OF WH	AT COUNTRY?
	E 1	100 Laurel Dr	ive				21921			J	J.S. A	Α.
1	NO.	11. MARITAL STATUS	12. WAS DECEDENT EVER	IN U.S. A	ARMED	13 WAS	DECENDENT OF HISPA	NIC OBIOINS (Basalfu Van	or No.	14 0405	- American Indien,
	- 1	1 Never Merried 2 Married	FORCES? 1 YES	2 [10 0	If yes	, specify Cuben, Mexico	n, Puerto Rici	in, etc.)	0 NO-	Black,	White, etc.
7	i a	3 Widowed 4 Divorced	IF YES, GIVE WAR OR	UAIES		1 '0	YES 2 NO Specif	ly:			Specify:	White
- 19		15. DECEDENT'S EDU	CATION	16a F	FCEDENT'S	USUAL OCCU	ATION	T 405 W	NO OF BUI	SINESS/IND	110700	
Ηi		(Specify only highest grade			(Give kind of y	vork done during	most of working	10D. KI	NU OF BUS	SINE 35/IND	USTRY	
5-	٦	Elementary/Secondary (0-12)	College (1-4 or 5+)			ction			Fire	work	rs.	
9	COMPL	17. FATHER'S NAME (First, Middle, Leet)		λ.	Loout	-01011						
5 5	5	Noach Thomas					18. MOTHER'S NA					
9 6	H H							rgini		17A		
	2	19e. INFORMANT'S NAME (Type/Print)					et end Number or Rural					0.4
E 1	- 1	Albertha Mae D	ove		94 Hi	untsm	an Drive	Elkt	on,	Md.	2192	21
2	- 1	20e. METHOD OF DISPOSITION 1 ☐ Burlel 2 ☐, Cremation 3 ☐ Rem	comi from State	b. PLAC	E AND DATE O	OF DISPOSITION	(Name of	DATE	20c. LO	CATION -	City or Town	n, State
E		4 Donation 5 Other (Specify)		R . A	remetory or of	rhar placa)	Inc.		Wes	t Ch	nest	er Pa.
ner		21. SIGNATURE OF FUNERAL SERVICE LIC				22. NAM	AND ADDRESS OF FA	CILITY				
any injury, or other traumatic event, the medical examiner must	- 1	▶ F-1 0M	ANOV. A.			Cee	Funera1	Home	250	E.	Main	n St.
8	_	envired 11.	1116/1 low n	*						17.1.1	rton	Md.
용	H	23. PART I. Enter the diseases, or can shock, or heart fallure.	emplications that ceuse List only one cause on	ed the c	feeth. Do n	ot enter the	mode of dying, suc	h aa cardlad	or respi	ratory arm	eat,	Approximate
E	1	IMMEDIATE CAUSE (Finel		00011 111		. 5						Interval Between Onset and Death
\$	ı	disease or condition resulting in desth)	(onges	A)	10 Y	Pores	ettanlu		1/10		_	E (1)
lent lent	- 1	resulting in destity	DUE TO (OR AS	A CONS	EQUENCE OF	7:	1 / 24/14	1	001	unce		- month
9 -	,	_	Carl	200	1.1	(C	-					Man and 15
Tage 3	2	Sequentially list conditions,	DUE TO (OR AS	A CONS	EQUENCE OF	pala						2. Months
trau Y	₹	if any, leading to immediate cause. Enter UNDERLYING	8 Horns	2+	0110	20100	Cardie	Val 8 1	.0.	Dolo	0-	10 Vocaso
10 10	£	CAUSE (Disease or injury that initiated events	DUE TO (OR AS	A CONSI	EQUENCE OF	7:		7 4200 ()	4 2	213	Eche	110/cars
2 2	Ē	resulting in death) LAST	4.4									
y, or other traumatic	3		d									
를 ;	ا ب	PART II. Other significent condition	s contributing to death	but not	resulting I	n the underl	ying ceuse given in	Part I. 24	e. WAS AN			VERE AUTOPSY FINDINGS
rs any inju	3 ∥	Doblett	as mell	2+	fus				PERFOR			WAILABLE PRIOR TO COMPLETION OF CAUSE
			11100					— '	YES 2	NO		OF DEATH?
shows	Σ	DID TORACCO LISE CONT	NIDUTE TO CALICE A) F D F	4711 1/2				•		1	YES 2 NO
23		DID TOBACCO USE CONTI	KIBUTE TO CAUSE (ИПП				
Item Item	3	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	28. PLA	ICE OF DEAT	OTHER:	ne)					
ed, or item	2	1 TES 2 NO	1 Inpetient 2 ER/Out	patient	3 DOA		tome 5 - Residence	6 Other (S	pecify)			
6 6	5	27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)		28b. TIME INJ	OF 28c.	INJURY AT WORK?	28d. DESCR	BE HOW I	JURY OCC	URED	
marked,	- 141	1 Natural 5 Pending 2 Accident Investigation	(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				YES 2 NO					
₩ C	- 10	3 Suicide 6 Could not be	280. PLACE OF INJUR	Y — At h	ome, ferm, s	treet, factory, o	ffice	281. LOCATIO	ON (Street e	nd Number	or Rural Rou	ite Number,
28 T		4 Homicide determined	building, etc. (Spe	ecrry)				City or T	own, Stete)			
E in	4 1	29e. CERTIFIER										
ANT: If Item 28			CIAN: To the best of my know									
E 8	3	2 MEDICAL EXAMINE	R: On the basis of examination	on end/or	r Investigation	n, in my opinio	n, death occured at the	time, date en	f place, en	d due to the	ceuse(s) e	nd manner ee atated.
E L	ı II	29b. SIGNATURE AND TITLE OF CERTIFIER	10106	/	,		29c. LICENSE NUM			29d. DATE	SIONED (N	Aonth, Day, Year)
IMPORTANT: If Item		proposatil	arlell-b.				222	307	7	16	5/25	1/95
₹ P	-	36-NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DE	EATH (IT	ЕМ 27) (Туре,	Print)				, ,	/	
		J.K. Patel, M.D.	123 Singer	cly	Avenu	e E	lkton, Md.	2192.	1	•		
		31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGI	NATURE					_			
		OCT 28, 1995 Ju	be Stwiles Ra									
	- 11	111.1 Z.B (33) Ya	AND THE PROPERTY OF THE PARTY O	CALLED								



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within SK hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Nem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE OF MARYLE REGISTRAR		MENT OF HEALTH AND	MENTAL HYGIEN	_			
10000	1. DECEDENT'S NAME (First, Middle, Lest) Margaret Louise H			2. DATE OF DEATH DO OCTOBER 1		3. TIME OF DEATH 1035 hrs M		
	218-16-5895 1 N 2 X 7		IF UNDER 1 YEAR IF UNDER 24 HRS. NONTHS DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Dey, Year) February 27,	0 104	ATHPLACE (State or Foreign untry) aryland		
TOR	9a. FACILITY NAME (If not institution, give street and number) Corsica Hills Nursing Home RESIDENCE OF DECEDENT		9b. CITY, TOWN OR LOCATION OF I		Queen .			
Corsica Hills Nursing Home Centreville Queen America of Decedent Consideration Control Co								
10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNT								
ВУ	11. MARITAL STATUS 1 Never Married 2 Married 3 X Widowed 4 Divorced 12. WAS DECEDENT EVER FORCES? 1 YES IF YES, GIVE WAR OR D	2 200	13. WAS DECENDENT OF HISP/ If yes, specify Cuban, Maxic 1 YES 2 NO Specify	can, Puerto Rican, etc.)	Bi St	ACE — American Indian, lack, White, etc. pecify: ite		
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	18e. DECEDENT'S U (Give kind of wo life. Do NOT use Homemak	rk done during most of working retired.)	Domesti				
BE CON	17. FATHER'S NAME (First, Middle, Lest) James Thomas Gears		Sophia		1.02000			
10	190. INFORMANT'S NAME (Type/Print) Melvin Hickman		DDRESS (Street and Number or Rura - Ingleside Road,					
	1 \ Burial 2 \ Cremation 3 \ Removal from State 4 \ Donation 5 \ Other (Specify)	D. PLACE AND DATE OF THE PROPERTY OF OTHER PROPERTY. CENTER OF THE PROPERTY OF	DISPOSITION (Nama of place) et place) etery - October 18	3, 1995 Stil	CATION City or 1. Pond, M	111111111111111111111111111111111111111		
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE William L. King Jr.	1/3/2	Fellows - Wel 413 West High St	lls Funeral reet. Chester	town. Mar	ryland 21620		
	23. PART I. Entar the diseases, or complications that cause shock, or heart failure. List only one cause on a IMMEDIATE CAUSE (Final disease or condition resulting in death)	d the death, book much lina.	t enter the mode of dying, su	ch aa cardiac or reapi	ratory arrest,	Approximats interval Between Onset and Death		
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	A CONSEQUENCE OF):						
SERTIFI	that initiated eventa resulting in death) LAST	A CONSEQUENCE OF):						
AL	PART II. Other algorificant conditions contributing to death is STROKE DEMENTER	out not reaulting in	tha undariying cause givan is	Part I. 24a. WAS AN PERFOR	MED?	24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 2 NO		
PHYSICIAN: MEDIC	DID TOBACCO USE CONTRIBUTE TO CAUSE C	OF DEATH YES		IN 🗆				
HYSIC	EXAMINER? 1	petiant 3 DOA 26b. TIME	OTHER: Nursing Nome 5 Rasidence OF 28c. INJURY AT	8 Cher (Specify)	NJURY OCCURED			
BY	1 Suicide 8 Could not be (Month, Day, Year) (Month, Day, Year) (Month, Day, Year) (Month, Day, Year) 28. PLACE OF INJURY building, atc. (Spe	— At home, farm, str	M 1 YES 2 NO	281, LOCATION (Street a	and Number or Run	al Routs Number,		
COMPLETED	4 Homicide datarmined		at the time, data and place, and ch					
- 11	(Check only one) 2 MEDICAL EXAMINER: On the basis of axamination		In my opinion, death occured at the	e time, data and placa, an	d due to the caus			
TO BE	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DE	ATH (ITEM 27) (Type, P	29c. LICENSE NU	V48	► 10	16/95		
,	31 DATE FILED (Month One Mari) 12 DECISTRADIS CANA	ATURE						
3	31. DATE FILED (Mogn), Day, Your) OCT 19 95 Julia Day	idson-Randa	W					

K 68760, BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

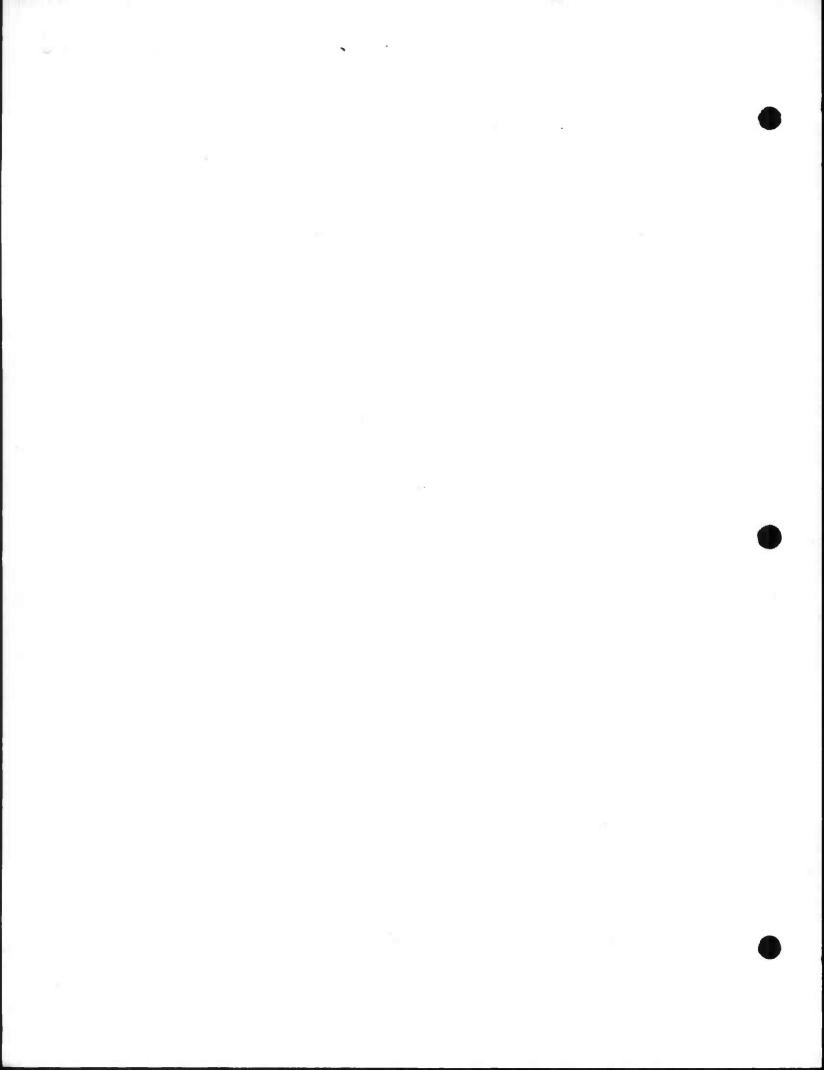
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FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REG. NO.

DECEDENT'S NAME (First, Middle, Leat)

2. DETECTION OF DAY MONTH
MONTH
DAY

											TIL	G. NO.			
		1. DECEDENT'S NAME (First, Lillian Is		Dickors	on Hi	llward					2. DATE OF DI	DAI	y 6 1 (YEAR	3. TIME OF DEATH
	H	4. SOCIAL SECURITY NUMB		5. SEX		yrs. lest birthde	/) #E 1	UNDER 1 YEAR	R IF UNDE	24 MDR	Octobe		J, 1:		1950 hrs. M
9		214-36-6073		1 □ M 2∑∏ F	o. Not (III	91 YRS.	MOM	THE DAYS		MIN,	(Month, Day, Februar	y 28	8,19	04 M	aryland
3 should	_	9a. FACILITY NAME (If not in					- 1		N OR LOCATI		ATN		9c. COU	NTY OF D	HTABLE
2	ECTOR	Chestertown		ilitation	Cent	er	er Chestertown						Ke	ent	
Des 1	띭	10a. STATE	10b. COUNTY			10c. C	TY, TO	WN OR LO	CATION						10d, INSIDE CITY
F. 2	PIB	Maryland	Ke	ent		Cl	nest	terto	wn						LIMITS?
perm	₹ I	10e. STREET AND NUMBER							101. ZIP COD	E			10g. CIT	ZEN OF	WHAT COUNTRY?
burial-transit permit. Pages 1,	FUNERAL	415 Morgne	c Rd.							620				ted :	States
urial-t	5	11. MARITAL STATUS 1 Never Married 2	Married	12, WAS DECEDEN FORCES? 1	YES	2 NO		13. WAS D	ECENDENT (OF HISPAN	HC ORIGIN? (Spen, Puerto Rican,	etc.)	or No-	14. RACI	E — American Indian, k, White, atc.
as the b	Э ВУ	3 🛣 Widowed 4 🗌 Divo		IF YES, GIVE W	AR OR DATE	ES		1 🗆 Y	ES 2XXNO	Specify	y:			Spec	White
nse	ETED	15. DEC (Specify only	EDENT'S EDUC y highest grade	completed)	1	8a. DECEDENT	'S USU	AL OCCUPA done during	TION most of worki	ng	16b. KIND	OF BUS	INESS/INC	DUSTRY	
è	PLE	Elementary/Secondary (0	12)	College (1-4 or 5	+)	Sales					Den	artn	nent	Stor	re
detach once.	COMPL	17. FATNER'S NAME (First, Mi	iddle, Last)			Dare	рег	LOCII	18, MOT	HER'S NA	ME (First, Middle,		_	500	
at be	i iii l	William E.	Dicke	erson						ma L					
5 should notified	10 B	19a. INFORMANT'S NAME (7)				1					Route Number, Cit				
be no	-	Helen H. Go							_	Apt.					Md. 21620
funeral director, page 5 should be detached ixaminer must be notified at once.		20a, METHOD OF DISPOSITI 1 ☑ Burlel 2 ☐ Crematio 4 ☐ Donation 5 ☐ Other	n 3 🗆 Remo	oval from State	cemete	ery, crematory of	other p	olece)		oher	19,95		ATION -		
ral dir		21. SIGNATURE OF FUNERAL	L SERVICE LIC	ENSEE //				22. NAME	AND ADDRE	SS OF FA	CILITY				1141
- T		▶ Gary B.		100	ry B.	telle	25	413	High	St.	ls Fune Chester	town	n, Mo	1. 2	1620
or removal.															Approximate Interval Between
y filled flon, or the m		IMMEDIATE CAUSE (Fin	nel			. 4		,							Onset and Death
ompletely i, cremati event, t		resulting in death)	→ ,	DUE TO	Card	ial i	2 f g	reti	00						
	z				(01. 10. 11.0)	ONGEOGENCE	Or j.								
inding physician and c Hygiene prior to buria or other traumatic	CATION	Sequentially list conditi If any, leading to immed cause. Enter UNDERLY!	diate	DUE TO	(OR AS A C	ONSEQUENCE	OF):								
physic ne pri	FIC	CAUSE (Disease or Injuithet Initiated events		DUE TO	(OR AS A C	ONSEQUENCE	OF):								-
the attending physician Mental Hygiene prior to njury, or other traun	RTIF	resulting in death) LAS	T ,	s.			,								
Menta Jury,	E	PART II. Other algorifice	nt condition	e contributing to	death but	not resulting	n in th	e underly	Ing cause	when in	Part I No.	WAS AN A	HIMMINA	1 000	
signed by the att Health and Menta ws any Injury,	DICAL	congest	1	eart fo	1	not resenting	y *** tri	o underly	mg cause	given in		PERFORI	MED?	240	AMILABLE PRIOR TO COMPLETION OF CAUSE
Health Health	AED A	insulin di		1 4	doc			· · · · · · · · · · · · · · · · · · ·			- '	YES 2	I NO		OF DEATH?
5 6 E		DID TOBACCO U				DEATH \	/ES [J NO		FRTAIN	<u>-</u>				1 YES 2 NO
2 Dec	CIAN	25. WAS CASE REFERRED TO EXAMINER?	- V		_	PLACE OF DE	ATH (C	heck only on							
the State of the State of the s	YSIC	1 VES 2 NO		HOSPITAL:	ER/Outpati	ent 3 🗆 DOA		HER: Mursing H	ome 5 🗆 Re	sidence	8 Other (Spec	cify)			
with th	F	27. MANNER OF DEATH 1 ☑ Netural 5 ☐ I	Pending	28a. DATE OF (Month, D			IME OF	1	NJURY AT WORK?		28d. DESCRIBE	NOW IN	JURY OC	CURED	
eath ma	β	2 Accident	Investigation	28 - PLACE O	E IN II IPW				YES 2	NO					
after 28 i	ETED		Could not be determined	building,	atc. (Specify)	At home, farm	i, street	i, fectory, of	fice		28f. LOCATION City or Town	(Street ar n, State)	nd Number	or Rural F	Toute Number,
DIRE hours	7	290. CERTIFIER	IFYING PNYSIC	CIAN: To the best of	my knowled	ge, death occu	rred et	the time, de	ate and place	, and dua	to the cause(s)	and mann	ner ee stat	led,	
FUNERAL within 72 P	COMPL														a) and menner as stated.
TO THE FUNERA be filed within 7 IMPORTANT:	BE (29b. SIGNATURE AND TITLE		Beenent	21/					ENSE NUN	4				(Month, Day, Year)
₽ 8 ₹	2	30. NAME AND ADDRESS OF	PERSON WHO			1 (ITEM 27) /K-	ne Prins	2)	03	3.5	//		- /	0-1	7-25
				The second	- or beat	- (11 Em 21) (19)	ra, rinn	,							i
	2	31. DATE FILED (Month, Day,		32. REGISTRA	S'S SIGNATI	JRE									
- 1	5	UCI .	19'95	9	ilia Dai	ridson-A	ande	رالا							
										_					



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physici	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-i	with the State Dept. of Health and Mental Hygiene prior to burfal, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
AN: The law requires that the death certificate be a	ificate has been signed by the attending physician	state Dept. of Health and Mental Hygiene prior to	r Item 23 shows any injury, or other traun
TO THE HOSPITAL OR ATTENDING PHYSICIA	TO THE FUNERAL DIRECTOR: After this certif	be filed within 72 hours after death with the	IMPORTANT: If Item 28 is marked, or

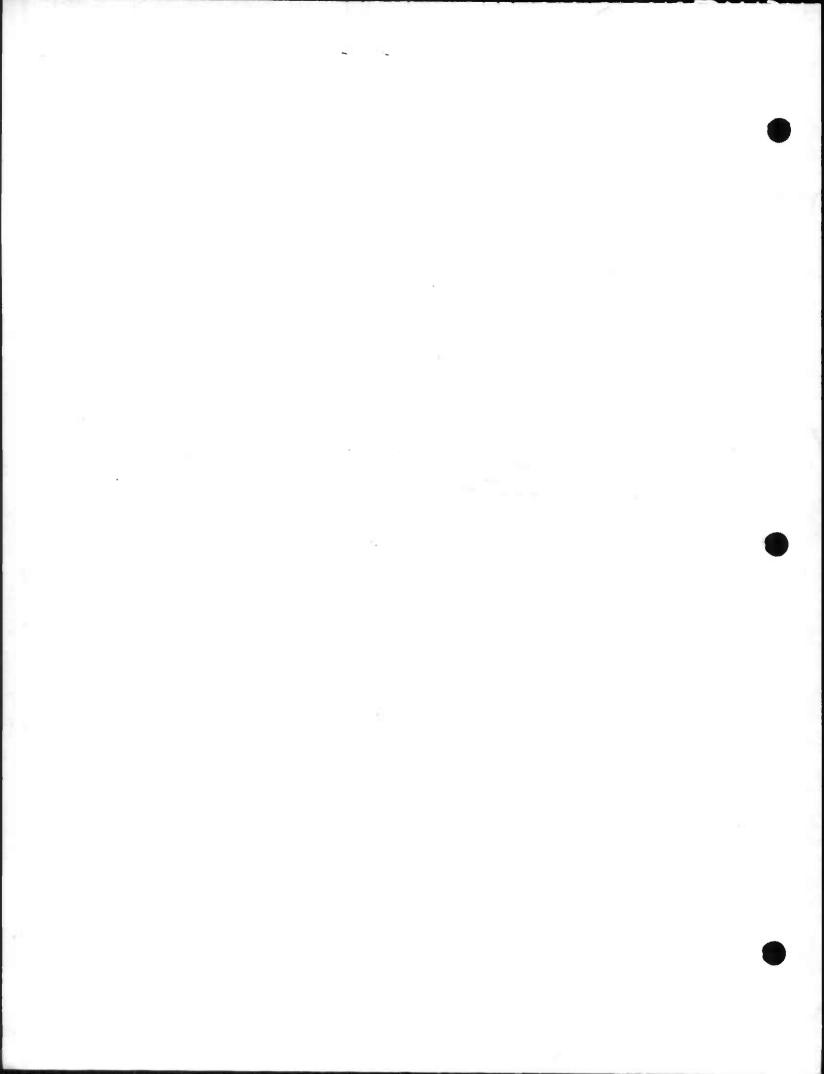
1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

1. DECEDENT'S NAME (First, Middle, Last)

Dorothy Codilers Beck Hypson

2. Date of Death Month 10 1/4

	1. DECEDENT'S NAME (First,								2. DATE C	F DEATH DA	Y	YEAR	3. TIME OF DEATH
Í	Dorothy Co	dilers	Beck Hy	nson					10	14		95	М
	4. SOCIAL SECURITY NUME		5. SEX	6. AGE (In yrs. las	t birthday)	IF UNDER	1 YEAR	IF UNDER 24 HRS.	7. DATE O	Day, Year)		8. BIRTH Countr	IPLACE (State or Foreign
1	215-18-498		1 🗌 M 2 💢 F	75	YRS.	wowins	OMIO	HOUNS IIIM.	05/1	19/20			roline Co,MD
_	9s. FACILITY NAME (If not in					OR LOCATION OF D	EATH		9c. COU	NTY OF D	EATH		
5	309 Burhca			C	hest	ertown			Qu	een_	Annes		
EC	10a. STATE	10b. COUNTY	Υ		10c. CIT	Y, TOWN C	OR LOCA	TION					10d. INSIDE CITY
DIRECTOR	MD	Quee	en Annes		Che	ster	town	n					LIMITS? 1 YES 2 NO
	10e. STREET AND NUMBER				10f. ZIP CODE				10g. CIT	IZEN OF	WHAT COUNTRY?		
FUNERAL	309 Burcha	rd Saw	Rd.					21620			U.	SA	
5	11. MARITAL STATUS 1 Never Married 2	Mandad		T EVER IN U.S. AR				ENDENT OF HISPA			or No-		E American Indian, k, White, atc.
ВУ	3X Widowed 4 Divo			MAR OR DATES			1 TYES	2 NO Speci	lly:			Bla	//y: ∩ k
	15. DEC	EDENT'S EDU	CATION	16a. DE	CEDENT'S	USUAL O	CCUPATI	ON	16b.	KIND OF BUS	SINESS/INC		CK
ET	(Specify onli Elementary/Secondary (C	y highest grade 0-12)	College (1-4 or 5	life.	ive kind of Do NOT u	work done see retired.)	during m	est of working					
ם	11		0		mest	ic				House	keep	er	
COMPLETED	17. FATHER'S NAME (First, M							18. MOTHER'S NA			Sumame)		
BE (Broden Bec	.k						Elizat	eth H	lenry			
10	196. INFORMANT'S NAME (т					and Number or Rural					
	James R. H	, ,	Jr.					ill Rd.		revil		MD .	
	20a METHOD OF DISPOSIT	on 3 🗌 Ram	oval from State	20b. PLACE.				ame of	1 O	18 Ma			
	4 Donation 5 Other 21. SIGNATURE OF FUNERA		CENGER	110.21	.011	22	NAME A	ND ADDRESS OF F	ACIL ITY				
	b							ie Smith					•
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Ē	that initiated events resulting in death) LAS	эт	002.10	(OII AS A CONGL	OUEHUE (, ,.							
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		Pending Investigation	(Month,	Day, Year)	IN	IJURY M		YES 2 NO					100
) BY	2 Accident 3 Suicide 6	Could not be	28e. PLACE	OF INJURY — At h	ome, farm,	atreet, fac	tory, offi	ce	281. LOCA	ATION (Street or Town, Stete)	and Numbe	er or Rural	Route Number,
TED	4 Nomicide	determined	Donain	n etc. (opecity)					l ony	n lown, Steller			
PLE	29a. CERTIFIER (Check only	TIFYING PHYS	SICIAN: To the best of	of my knowledge, d	aath occur	rred at the	time, dat	s and piece, and du	s to the cau	se(a) and ma	nner as st	ated.	
COMPLET	anal .	DICAL EXAMIN	ER: On the beals of	examination and/or	Investigat	lon, in my	opinion,	death occured at th	e time, deta	and place, ar	nd due to 1	the cause	a) and manner as stated.
	29b. SIGNATURE AND TITL	E OF CERTIFIE	RALAO					29c. LICENSE NU			29d. DA	TE SIGNE	D (Month, Day, Year)
D BE	5	UL A	Nove	- mr	>			1)4	158	7	•	10-	17-95
5	30. NAME AND ADDRESS C	F PERSON W	NO COMPLETED CA	USE OF DEATH (ITE	EM 27) (Typ	e, Print)							
32	M DATE THE CO. 11	Mari		A MID PLANT						- :			
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BALTIMORE, MARYLAND 21215-0020

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DIVISION OF VITAL RECORDS, P.O. BOX 68760,

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TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending p	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the be filed within 72 hours after death with the State Deut, of Health and Mental Hotelee prior to burial, cremation, or removal.	MPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
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31. DATE FILED (Month, Day, Year)

32. REGISTRAR'S SIGNATURE

whia Davidson-Randelle

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH 199 Oliver Murray Hopkins 7:45 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH
(Month, Day, Year)
Jan. 15, 1917 IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 217-12-4849 1 X M 2 - F 78 MD 9a. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 21606 Lovers Lane FUNERAL DIRECTOR Rock Hall Kent RESIDENCE OF DECEDENT 10a. STATE MD 10c. CITY, TOWN OR LOCATION ROCK Hall 10b. COUNTY 10d. INSIDE CITY LIMITS? Kent 1 YES 2 NO 10e. STREET AND NUMBER 21606 Lovers Lane 10f. ZIP CODE 0g. CITIZEN OF WHAT COUNTRY? 21661 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indien, Black, White, etc. 1 Never Married 2 X Merried If yea, specify Cuben, Mexican, Puerto Rican, etc.) IF YES, GIVE WAR OR DATES 1 YES 2 X NO BY Specify 3 Widowed 4 Divorced **Black** COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY ntary/Secondary (0-12) College (1-4 or 5+) 6th Truck Driver Fireworks Mfg. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malden Sumame) Henry Hopkins Erie Johnson BE 190. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 21606 Lovers Lane, Rock Hall, MD 21661 Elaine Hopkins 20a, METHOD OF DISPOSITION
1 N Burlel 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State Aaron Chapel Cemetery 10/25/95 Rock Hall, MD 4 Donation 6 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY James A. Perkins Funeral Ser. James a P. O. Box 143, Rock Hall, MD 21661 -Penkins 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata ahock, or heart fallure. List only one cause on each line. interval Batwer IMMEDIATE CAUSE (Final **Onset and Death** disease or condition UNG CANCER resulting in death) 1. DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequantially list conditiona, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated eventa DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST PART ii. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part i. PHYSICIAN: MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 24a. WAS AN AUTOPSY PULMONARY 1 YES NO 1 TYES 2 NO 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 28. PLACE OF DEATH (Check only one) HOSPITAL:
1 | Inpatient 2 | ER/Outpatient 3 | DOA OTHER: 1 TES 2 NO ng Home 5 Residence 8 - Other (Specify) 4 🗌 Nurs 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d, DESCRIBE HOW INJURY OCCURED Netural N 5 Pending м 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Sulcide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined COMPLETED 4 Homicide 1 CERTIFYING PHYSICIAN: To the beat of my knowledge, death occurred at the time, date end place, end due to the cause(e) end menner ee atated. 2 MEDICAL EXAMINER: On the basic of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Day, Year) 29c. LICENSE NUMBER BE D41587 10-24-9 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) HELEN A NOBLE I 22 SPEER RD STEATS CHESTERTOWN MD

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	1 - FOR STATE REGISTRAR	STATE OF MARY	AND / DEPARTMEN CERTIFICAT	T OF HEALTH AND E OF DEATH	MENTAL HYGIEN		
37	1. DECEDENT'S NAME (First, Middle, Last) May 4 4. SOCIAL SECURITY NUMBER	AD N'	HEN JER.	SOM II t YEAR IF UNDER 24 HRS.	2. DATE OF DEATH MONTH 10 - 2 3		3. TIME OF DEATH 8 200 IRTHPLACE (State or Foreign
TOR	578-24-9985 90. FACILITY NAME (If not institution, give stre PINEVIEW NUSLING RESIDENCE OF DECEDENT	1 M 2 KF	89 YRS. MONTHS	DAYS HOURS MIN.	(Month, Day, Year)	C	HARLES CO., DE DEATH
DIRECTOR	10a. STATE 10b. COUNTY	Georges	10c. CITY, TOWN	or Location			10d. INSIDE CITY LIMITS? 1 K YES 2 NO
RAL	100. STREET AND NUMBER 9106 Pineview Lar	ne .		10f. ZIP CODE 20735			OF WHAT COUNTRY?
BY FUNERAL		12. WAS DECEDENT EVER FORCES? 1 YES IF YES, GIVE WAR OR (2 X NO	WAS DECENDENT OF NISP. If yes, specify Cuben, Mexic 1 YES 2 NO Specific No. Specif	can, Puerto Rican, etc.)	14. F	d States ACE - American Indian, Black Black
COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade of Elementary/Secondary (0-12)	TION ompleted) College (1-4 or 5+)	16a. DECEDENT'S USUAL. (Give kind of work done life. Do NOT use retired. House Ke	eeper	U.S.	siness/industr	RY .
BE CO	17. FATNER'S NAME (First, Middle, Last) Charles Datcher			Mori	AME (First, Middle, Melder ah Hawkins		
5	190. INFORMANT'S NAME (Type/Print) Viola Martin			S (Street end Number or Rura N. 28th Ave			,
	20 HETHOD OF DISPOSITION Cremation 3 Remov	ral from State 20	b. PLACE AND DATE OF DISPO	SITION (Name of	DATE 20c. LO	CATION - City of	or Town, State
	21. SIGNATURE OF FUNERAL BERVICE LICE	e S.		NAME AND ADDRESS OF P Alexander S 5538 Marlbo	ro Pike Fo	restvil	mes le, MD 2074
	/23. PART I. Enter the diseases, or co shock, or heart failure. Li IMMEDIATE CAUSE (Final disease or condition resulting in death)	ATHER D	SCLER	ofic HBA	ART DIS	BASE	Approximate Interval Betwoonset and D
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DOE TO (OR AS	A CONSEQUENCE OF): A CONSEQUENCE OF): A CONSEQUENCE OF):	VASCU	LAR PI	SEASE	E 6 Ma
MEDICAL	PART II. Other significent conditions	contributing to death	but not resulting in the u	nderlying ceuse given i		RMED?	24b. WERE AUTOPSY FINDS AMAILABLE PRIOR TO COMPLETION OF CAUS OF DEATH? 1 YES 2 NO
SICIAN:		HOSPITAL:	OTHE		T-Cra to be		
ву РНУ	27. MANNER OF DEATN 1 Netural 5 Pending 2 Accident Investigation	28e. DATE OF INJURY (Mooth, Day, Year)	28b. TIME OF NUTRY N/A M	28c. INJURY AT WORK? 1 YES 2 NO	28d. DESCRIBE NOW		D
0	3 Suicide 8 Could not be determined	28e. PLACE OF INJUR building, atc. (Spe	Y — At home, lerm, street, factory) N/A	ctory, office	281. LOCATION (Street City or Town, State	and Number or Ru N/A	
COMPLET			wiedge, death occurred at the on end/or investigation, in my				se(s) end menner es state
TO BE (296. SIGNATURE AND TITLE OF CERTIFIED 30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CALLOS OF THE	MDFACE	29c. LICENSE NO	7744	29d. DATE SIG	NED (Month, Day, War) 0.24, 95
	RAJ. SAMTAN	1 MD	9131 PiSc	ATAWAY	PD Ci	into	NMD 21
Í	OCT 27 1995	32. REGISTRAR'S SIGI	NATURE Parlate				_

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the physician.	to the field within 27 hours after death with the State Bert 1 of Health Hydrele prior to bunda, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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	1 - STATE REGISTRAR	STATE OF MA			TMENT				ENTAL HYGIEN REG. NO.	E		
	DECEDENT'S NAME (First, Middle, Last) L L L SOCIAL SECURITY NUMBER	AN	1+A	11					2. DATE OF DEATH DO	199	5 PEAR	3. TIME OF DEATH
	578-26-5017	1 🗆 M 2 🔀 F	AGE (In yrs. lest	YRS.		DAYS	HOURS	MIN.	7. DATE OF BIRTH (Morith, Day, Year) August 26,		L Pa	int Rock,
OR	90. FACILITY NAME (If not institution, give s WASHINGTON ADVEI		PITAL				er Location a Par	N OF DEAT	гн		NTY OF DE	
2	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY	Y		10c CIT	Y, TOWN OR	LOCAT	TON					
AL DIRECTOR	Maryland Prince	e George's	5		Oxon l	Hil				10a CITI		10d, INSIDE CITY LIMITS? 1 YES 2 NO HAT COUNTRY?
ER/	2020 Alice Avenue	e, #202				-	207					States
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. WAS DECEDENT I FORCES? 1 _ IF YES, GIVE WAR	YES 2X N	MED O	If y	res, spi	ENDENT OF	n, Maxican,	ORIGIN? (Specify Yes Puerto Rican, etc.)		14. RACE Black, Specify	- American Indian, White, etc.
	15. DECEDENT'S EDU	CATION	16a. DE0	CEDENT'S	USUAL OCC	UPATIC	N .		16b. KIND OF BUS	INESS/IND		STACK
COMPLETED	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5 +)	(Gh	ve kind of a Do NOT us	vork done dur	ring mo	st of working		(HUD)			ıt
CO	17. FATHER'S NAME (First, Middle, Last)						18. MOTH	ER'S NAME	(First, Middle, Meiden			
BE	William Stone 190. INFORMANT'S NAME (Type/Print)		l tree		-				invard			
5	Rosa Ellison Tur	ner	2.5.0						te Number, City or Town			.c. 20032
	20e. METHOD OF DISPOSITION		20b. PLACE A	ND DATE	F DISPOSITI						City or Tow	
	4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LIC		Linco	ln Me	emoria	al o	Cemet	ery	10/26/95	Suit	land.	Maryland
	21. SIGNATURE OF FUNERAL SERVICE LIC	ZA +	L -11		STI	LWA AN	RT FU	NERA	L HOME			
	AONM / S	Lewari	111		400)1	Benni	ing R	oad, N.E.	,Wash	ningt	on, D.C.
	23. MART I. Enter the diseases, or o shock, or heart failure. IMMEDIATE CAUSE (Finel disease or condition resulting in death)	a. Brady	on each line.				1.			ratory arr	est,	Approximata interval Between Onset and Death
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in deeth) LAST	DUE TO (O	SINUS RAS A CONSED RAS A CONSEO	SL) UENCE OF	ndroi							2 minths
MEDICAL	Diabetes mellity	1/	peth but not re		n the unde	erlying	ceuse g	iven in Pa	24a. WAS AN PERFOR	MED?		WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
ä	DID TOBACCO USE CONTE	RIBUTE TO CAU	SE OF DEAT	TH YE	S N	KĮ C	UNC	RTAIN				
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO WINCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? 1 VES 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 28. DATE OF INJURY (Morth, Day, Year) 28. DATE OF INJURY AT WORK? 28. INJURY AT WORK?												
HYS	1 YES 2 NO 27. MANNER OF DEATH	1 b Inpatient 2 E		DOA 28b, TIMI	4 - Nursin	g Home			Other (Specify)			
ВУ Р	1 Natural 5 Pending	(Month, Day,		INJ		WO	RK?		8d. DESCRIBE HOW IN	DUHY OCC	URED	
	2 Accident Investigation 3 Suicide 8 Could not be determined 4 Homicide Homicide Could not be determined 5 Accident Investigation M TYES 2 HO 5 Accident Investigation M TYES 2 HO 6 Accident Investigation M TYES 2 HO 7 Accident Investigation M TYES 2 HO 7 Accident Investigation M TYES 2 HO 7 Accident Investigation M TYES 2 HO 7 Accident Investigation Accident						ute Number,					
COMPLETED	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSIC (Check only one) 2 MEDICAL EXAMINED											and manner as stated.
TO BE C	296. SIGNATURE AND TITLE OF CERTIFIER	n MD					29c. LICE	SE NUMBE	ER	29d. DATE	SIGNED (Month, Day, Year)
-	Non-ton Elsin	MD 65	25 B	le le le	STR	Q	Hyn	theri	lle, MD	20	782	
	31. DATE FILED (Month, Day, Year) OCT 27 1995	32 MEGISTRAR'S	SIGNATURE	Lok								

DIVISION OF VITAL RECORDS, P.O. BOX 6876

BALTIMORE, MARYLAND 21215-0020

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

				DEPARTMENT OF HEALTH AND MENTAL HYG	ENE	
NDED ;	#18	10/30/95	EIM	PGC	95	3391

	1 - STATE REGISTRAR	STATE OF M				F HEALTH		MENTAL HYGIEN REG. NO			
	1. DECEDENT'S NAME (First, Middle, Last)				0/11 -	J. DEA		2. DATE OF DEATH			3. TIME OF DEATH
	RHONDA	LEE			HILLI			OCTOBER	21,1	_	2016 P M
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last bin		IF UNDER 1 YE	AR IF UNDE	R 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)		Countr	
- 1	411-31-3578	1 M 2 X F	32	YRS.				Jan. 31,1			ifornia
2	9e. FACILITY NAME (If not institution, give :					WN OR LOCAT		EATH	9c. COL	JNTY OF D	EATH
ECION	PRINCE GEORGES	HOSPITA	AL CENTE	R	CHF	VERLY			PRI	NCE	GEORGES
	10e. STATE 10b. COUNT	Υ	-10	Oc. CITY,	TOWN OR L	OCATION					10d. INSIDE CITY LIMITS?
E C		e George	S	Ri	iverda	le					1 🙀 YES 2 🗌 NO
\$	10e. STREET AND NUMBER					101, ZIP COE			10g. CIT	TIZEN OF Y	VHAT COUNTRY?
FUNEHAL	6008 Riverdale Ro					2073				S.A.	
BY FU	1 Never Married 2 Married 3 Widowed 4 Divorced		TEVER IN U.S. ARMED YES 2 NO AR OR DATES	,	If ye	s, specify Cub YES 2 NO	en, Mexica	NIC ORIGIN? (Specify Ye in, Puerto Ricen, etc.) 'y:	e or No	14, RACE Black Speci	E — Americen Indian, k, White, etc. hy: White
	15. DECEDENT'S EDU		16a. DECED	ENT'S U	JSUAL OCCU	PATION		16b. KIND OF BU	JSINESS/IN	DUSTRY	WILLEC
-	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+	life Do	NOT use	ork done durir retired.)	g most of work	ing				
COMPLETED		2	Artis	st				Self-	Emplo	yed	
3	17. FATHER'S NAME (First, Middle, Last)							ME (First, Middle, Maider	Sumame)		
<u> </u>	Levi N. Hilling						rici		ner J		
2	190. INFORMANT'S NAME (Type/Print) Levi N. Hilling							Route Number, City or Tox OX R-139, 1		4	914 2400
	200. METHOD OF DISPOSITION		20b, PLACE AND				00 00	The same of the sa	DCATION -		
	1 Donation 5 Other (Specify)	oval from Stata	Metropo	ory or oth	an Cr	emator	y 10	1/27/95 Ale	exand	ria.	Virginia
	21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE	1		22. NAR	E AND ADDR	ESS OF FA	CILITY			
	1/4 rules for	BOD	1					's Sons Fu			
\neg	23. PART I, Enter the diseeses, or	complications that	used the deeth	. Do no	of enter the	mode of dy	ying, suc	e Ave., Hya	olratory s	rrest,	Approximate
	ahock, or heert fellure. IMMEDIATE CAUSE (Final disease or condition resulting in death)	a	OF AS A CONSEQUE	NCE OF	S	è-					Interval Between Onset and Death
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST	b. DUE TO	OR AS A CONSEQUE	NCE OF)):	n					
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SICIAN	25. WAS CASE REFERRED TO MEDICAL				H (Check only		-				
2	EXAMINER? 1 X YES 2 NO	HOSPITAL:	ER/Outpatient 3	DOA	OTHER: 4 Nursing	Home 5 🗆 F	Reeldence	6 C Other (Specify)			
YHY	27. MANNER OF DEATH	28e. DATE OF (Month, Di	INJURY 20	8b. TIME		c. INJURY AT WORK?		28d. DESCRIBE HOW	INJURY O	CCURED	
- 0	1 Accident 5 Pending Investigation				M 1	YES 2	□ NO				
2	3 Suicide 8 Could not be 4 Homicide determined	28a. PLACE O building,	F INJURY — At home, etc. (Specify)	farm, st	treet, factory,	office		281. LOCATION (Street City or Town, State		er or Rural I	Route Number,
COMPLE	1 CERTIFYING PHYS							e to the cause(e) and me			e) end menner as steted.
ם מ	THE SIGNATURE AND TITLE OF CERTIFIE	R /	4 ^			29c. LIC	CENSE NU	MBER	29d. DA	TE SIGNED	(Month, Day, Yeer)
	Lawr	-corp	MU			0.	C.M	.E.	Poc	TOB	ER 22,1995
=	HAME AND ADDRESS OF PERSON WI	KE, MD	111 Pen	n S				more, Ma			111
	31. DATE FILED WORD Day YOR! 199	32. REGISTRA	S'S SIGNATURE	44			HERELOT SOL				

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BALTIMORE, MARYLAND 21215-0020	4 hours after death. Page 6 may be retained by the hospital or attending physician.	centificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should in the State Dept. of Health and Memai Hygiene prior to burial, cremation, or removal.	ne medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the be filed within 72 hours after death with the State Dept. of Health and Memtal Hygiene prior to burlal, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

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	FOR 1 - STATE REGISTRAR	STATE OF MARYL		TMENT OF I		MENTAL	HYGIENE REG. NO.				
- 15	1. DECEDENT'S NAME (First, Middle, Last)	William G.	Hender	son		MONTH	of DEATH DAY	, 1995	AR	L:45 P	м
¥		. SEX 8. AOE (1) 76	fn yrs. last birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE	0F BIRTH 3/11/9 ^{ar)}	a. B		ce (Stete or Foreign	
OR	90. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 11105 Old Fort Rd. 9c. COUNTY OF DEATH Ft. Washington Prince Ge										
DIRECTOR	nesidence of decedent 10a. state 10b. county Maryland Prince	George's		TOWN OR LOCA						I. INSIDE CITY LIMITS?	
-	100. STREET AND NUMBER 11105 Old Fort Rd.				20744			109. CITEZEN USA	OF WHAT	COUNTRY?	\exists
BY FUNERAL		2. WAS DECEDENT EVER IN FORCES? 1 X YES IF YES GIVE WAR OR DA	2 NO	If yea, s	CENDENT OF HISPAI pecify Cuben, Mexica S 2 NO Specif	n, Puerto F			RACE — A Black, WI Sqecily: 11 te	American Indien, hite, etc.	
COMPLETED	15. DECEDENT'S EDUCAT (Specify only highest grade cor Elementary/Secondary (0-12)	(ION mpleted) Coflege (1-4 or 5+)	16a. DECEDENT'S (Give kind of w life. Do NOT us	rork done during m		16b.	. KIND OF BUSIN	ESS/INDUST	RY		
MPI	9th		Taxi Ca	b Drive			ranspo		n		_
8	17. FATHER'S NAME (First, Middle, Last)				16. MOTHER'S NA			rname)			
BE	William A. Hender	son	1		Mazi						_
2					and Number or Rural	Route Numb	ber, City or Town.	State, Zip Cod	(e)		
	Diane V. Henderson			as item		DAT	- 100-1004	ITION — City	as Taura	State.	-
	1 Buriel 2 Cremation 3 Remova 4 Donation 6 Dipher (Specify)	I from State	PLACE AND DATE Of tetery, crematory or of	har placa	atory 10						
	21. SIGNATURE OF MERAL SERVICE LICEN		croporre	22. NAME /	ND ADDRESS OF FA	CILITY			, , ,	1.	\dashv
	* Shore P. K	also (1)	1	George 6160 (e P. Kala Oxon Hill	ıs Fuı ., Md	. 20745				
	23. PART I. Enter the diseasea, or conshock, or heart failure. Lie IMMEDIATE CAUSE (Final disease or condition resulting in death)	Sloo	d the death. Do nach line.	Con	ode of dying, aud		diac or reapire	itory arrest,		Approximate Interval Betwee Onset and Dec	
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF	F):							
EDICAL (PERFORMED? ANALL COMP								RE AUTOPSY FINDING MARIE PRIOR TO MPLETION OF CAUSE DEATH?		
Σ	DID TOBACCO USE CONTRIB	PLITE TO CALISE O	E DE ATH VE	S [] NO [T HNCEDTAL	NI ISI			1 [YES 2 NO	
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEAT								
SIC		OSPITAL:	patient 3 DOA	OTHER: 4 Nursing No	me 5 X Residence	6 🗆 Othe	er (Specify)				
ЭНУ	27. MANNER OF DEATH	28e. DATE OF INJURY (Month, Day, Year)	28b. TIM		JURY AT	28d. DES	SCRIBE HOW IN	JURY OCCUR	ED		\Box
ВУ	1\ Accident 5 Pending Investigation	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			YES 2 NO						
ETED E	2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide determined 26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)								Number,		
COMPLE	29e. CERTIFIER (Check only one) 1 CERTIFYINO PHYSICIA 2 MEDICAL EXAMINES:	AN: To the best of my know On the bests of examination							use(s) en	d manner es stated	1.
BE	29b. SIGNATURE AND TITLE OF CERTIFIER	richal	Del	1	DZ494	MBER 5				25, 199)5
10	Michael D. Levine,	M.D. 7801	01d Bran	ch Ave.	Clinton	, Md.	20735				
	31. DATE FILED (Month, Day 1987)	35 SECRETARING CHEM	IAOME .								

DIVISION OF VITAL RECORDS, P.O. BOX 68760	BALTIMORE, MARYLAND 21215-0020
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	ge 6 may be retained by the hospital or attending physician.
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IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	r must be notified at once.

	FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPART	MENT OF H	EALTH AND I	MENTAL HYGIEN		
	1. DECEDENT'S NAME (First, Middle, Last)	D to	to LLAN	17)		2. DATE OF DEATH	AY 7-199	3. TIME OF DEATH P
	4. SOCIAL SECURITY NUMBER		r yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	Co	PTHPLACE (State or Foreign unity)
	579-18-5478	1x M 2 G F 7	3 YRS.		HOURS MIN.	Sept 10 1		wie, MD
CTOR	SOUTHERN PRESIDENCE OF DECEDENT		PITAL	9b. CITY, TOWN C	NTON	АТН	PAIN	(2)
FUNERAL DIRECTOR		Georges		restvil	le, Mary	Land		10d. INSIDE CITY LIMITS? 1 X YES 2 NO
RAL	10e. STREET AND NUMBER			101	ZIP CODE			F WHAT COUNTRY?
NE	7420 Marlboro Pik	2. WAS DECEDENT EVER IN	II C ADMED	11 10 1100 000	20747			d States
ВУ	1 Never Married 2 Married	FORCES? 1 VES YES IF YES, GIVE WAR OR DA	2 NO	If yes, spi	ecity Cuban, Mexical 2 NO Specify	IC ORIGIN? (Specify Yes n, Puerto Rican, etc.)	В	ACE — American Indian, lack, White, atc. Decily: Black
red	15. DECEDENT'S EDUC. (Specify only highest grade of	ATION	16a. DECEDENT'S L	SUAL OCCUPATION done during mo	N st of working	16b. KIND OF BU	SINESS/INDUSTR	Υ
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)	Form	Setter		C	onstruci	rian
OMI	17. FATHER'S NAME (First, Middle, Last)			occcer -	16. MOTHER'S NAI	ME (First, Middle, Malden		1011
BE C	John A Holland					Clifford	Surremey	- 3
TO B	19a. INFORMANT'S NAME (Type/Print) Richard C. Hollar	nd Jr	19b. MAILING /	ADORESS (Street a	nd Number or Rural F	oute Number, City or Tow South Fore:	n, State, Zip Code)	MD 20747
	20a. METHOD OF DISPOSITION 1 Buriel 2 Cremation 3 Ramo 4 Donation 5 Other (Specify)	val from State 20b.	PLACE AND DATE OF other, cremetory or other Chelter	F DISPOSITION (Na ar_place)	ma of		CATION — City or	
	21. SIGNATURE OF TUNERAL SERVICE LICE		Chelter		O ADDRESS OF FAC		Chelten!	nam, MD
	· 1048-2	n. 11L		Alex	ander S.	Pope Fune		nes Le, MD 20747
	23. PART I. Enter the diseasea, or co ahook, or heart fallure. L	mplications that caused	the deeth. Do no	ot enter tha mo	de of dying, such	n as cerdiac or respi	ratory arrest,	Approximata Interval Between
	IMMEDIATE CAUSE (Fine) disease or condition resulting in death)	Acute OUE TO (OR AS A		porch	infar	ction		Onset and Death
z		SEPTICO DUE TO (OR AS A		6.0		monia		
CERTIFICATION	Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A	CONSEQUENCE OF	- 0	1100	Thatte		
5	CAUSE (Disease or Injury that initiated events	OUE TO (OR AS A	CONSEQUENCE OF	allur	Q.			A THE STATE OF THE
E	resulting in death) LAST	,	7.5					İ
	PART II. Other algnificent conditions	contributing to death by	t not regulting in	the underlying	nikas atras ta t	Deat		
CAL	The state of the s	contributing to death bu	t not resulting in	the underlying	ceuse given in i	PERFOR	MED?	24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE
PHYSICIAN: MEDIC						1 TES 2	X	OF DEATH?
ž	DID TOBACCO USE CONTR	IBUTE TO CAUSE OF	DEATH YES	□ NO □	UNCERTAIN	10		1 123 2 100
CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HQSPITAL:	6. PLACE OF DEATH					
YSI	1 TES 2 NO	1 Inpatient 2 ER/Outpa	tient 3 DOA		5 - Residence	6 Other (Specify)		
	27. MANNER OF DEATH 1 Natural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME INJU	RY WO		28d, DESCRIBE HOW I	NJURY OCCURED	
ЭВУ	2 Accident Investigation 3 Suicide 8 Could not be	28a. PLACE OF INJURY -	– At home, farm, st			26f. LOCATION (Street s	and Number or Run	al Route Number.
COMPLETED	4 Homicide determined	building, etc. (Specif	(y)			City or Town, State)		
APL		IAN: To the best of my knowle						
S	2 MEDICAL EXAMINER	On the basis of examination	and/or investigation	, in my opinion, de	eath occured at the	time, date and place, an	d due to the cave	e(s) and manner as stated.
BE	29b. SIGNATURE AND TITLE OF CERTIFIER	FARG 6.	and DAG		29c. LICENSE NUM	BER	29d. DATE SIGN	ED (Month, Day, Year)
2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF GEA	TH (ITEM 27) (Tone	- UMD	D464	18	10	18-95
	Suresh Patelin				Suit	e200 0	Frain	mD20735
	31. DATE FILED NO. 10 23 1995	32. PEGISTRAN'S SIGNA	TURE		· sull	C. TUR,	-1119	1 (11796 137
	001 20 1995	June 20 and	- ANDREAD					

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OTATE OF MADY!	ND / DEDARTMENT		
STATE OF MARYLA	INU / DEPAKTMENT	OF HEALIH AND	MENTAL HYGIENE
	CERTIFICATE	OF DEATH	DEC NO

1	FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPARTI CERTIFIC				HYGIENE REG. NO.				
j i	1. DECEDENT'S NAME (First, Middle, Last)			2.0.		2. DATE OF			3. TIME OF DEATN		
	Walter	Hill			4:44 P						
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE		IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (STIM							
- 14-	224-48-8825 9a. FACILITY NAME (If not institution, give s		0 YRS.	March 18,1935 Co., Virgi							
						EATN		c. COUNTY			
	Holy Cross Hospit	a1		Silver	Spring			Montg	omery County		
	10a. STATE 10b. COUNT			OWN OR LOCAT	ION				10d. INSIDE CITY LIMITS?		
- 11-		omery County	Sil	ver Spr					1 TYES 2 X NO		
1	O.E.C.O	11000		101	ZIP CODE				of what country? d States		
- 11-	8560 Second Avenu	12. WAS DECEDENT EVER I	IN II O ADMED	1	20910			of Am			
- 14	1 Never Married 2 Married	FORCES? 1 YES	2 X ND	If yes, sp	ENDENT OF HISPA	en, Puerto Rice			RACE — American Indian, Black, White, atc.		
	3 Wildowed 4 Divorced	IF YES, GIVE HAN ON D	MIES	1 TES	2 NO Specif	ry:			Specify: Black		
	15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	16a. DECEDENT'S US (Give kind of work			16b. KI	ND OF BUSIN	ESS/INDUST	RY		
	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT use n	etired.)							
-	8 17. FATHER'S NAME (First, Middle, Last)		Disab.	Lea			None				
- 10	Johnson Hill				Alice F			-			
11-	19a. INFORMANT'S NAME (Type/Print)		10h MAH ING AF	MARCO / STANCE	nd Number or Rural				4-1		
н	Evelyn Smith Hill								ng, MD 20910		
	20a. METHOD OF DISPOSITION	201	b. PLACE AND DATE OF I	DISPOSITION (Na	med .						
	1 Burial 2 Cremation 3 Rem 4 Donation 5 Other (Specify)	oval from State	b. PLACE AND DATE OF I	aptist	Church	1995	Virg	ingna inia	m County		
	21. SIGNATURE OF FUNERAL SERVICE LIC			22, NAME AN	D ADDRESS OF FA	CILITY					
1	Khund	Dearn	C 4 A		d-Reid F				, Virginia		
1	23. PART I. Enter the diseases, or	complications that cause	d the death. Do not	enter the mo	de of dylng, suc	h as cardia	c or reapirat	lory arrest,	Approximate		
- 1	shock, or heert fellure. List only one cause on each line.										
ш											
	disease or condition	. CARDI	AC ARI	RAST					Onset and De		
	disease or condition resulting in death)	a. CARDI DUE TO (OR AS									
	disease or condition resulting in death)	CONGES.	TIVE H		FAILUI	rE					
	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	b. CONCES. DUE TO (DR AS	TIVE H	EART		re					
	disease or condition resulting in death) Sequentially list conditions, if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	b. CONGES. DUE TO (DR AS AS C. DIABETI	TIVE H A CONSEDUENCE OF:	EART		r E			4 years		
	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	b. CONGES. DUE TO (DR AS AS C. DIABETI	TIVE H	EART		rE					
	Sequentially list conditions, if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. CONCES. DUE TO (DR AS A DUE TO (DR AS A DUE TO (DR AS A	A CONSEDUENCE OF): A CONSEDUENCE OF):	EART							
	disease or condition resulting in death) Sequentially list conditions, if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. CONCES. DUE TO (DR AS A DU	A CONSEDUENCE OF): A CONSEDUENCE OF):	EART			ta. WAS AN AU PERFORME		20 years 20 years 24b. WERE AUTOPSY FINDIN ANALABLE PRIOR TO		
The second secon	Sequentially list conditions, if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. CONCES. DUE TO (DR AS A DU	A CONSEDUENCE OF): A CONSEDUENCE OF):	EART		Part 1. 24		ED?	4 years 20 years		
	Sequentially list conditions, if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (DR AS A DUE TO (DR AS	A CONSEDUENCE OF): A CONSEDUENCE OF): Dut not resulting in	EANT	g cause given in	Part I. 24	PERFORME	ED?	20 years 20 years 24b. WERE AUTOPSY FINDIN ANALABLE PRIOR TO COMPLETION DO CAUSE		
	Sequentially list conditions, if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significent condition THYPO THYRO DID TOBACCO USE	DUE TO (DR AS A DUE TO (DR AS	A CONSEDUENCE OF): A CONSEDUENCE OF): Dut not resulting in	EART LIVS the underlying	g cause given in	Pert I. 24	PERFORME	ED?	20 years 20 years 24b. WERE AUTOPSY FINDIN ANALLABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
	Sequentially list conditions, if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significent condition PART II. Other significent condition DID TOBACCO USE 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	b. CONCES. DUE TO (DR AS A DU	A CONSEDUENCE OF): A CONSEDUENCE OF): but not resulting in the conseduence of the conse	DEATH Y	CES NC	Part I. 24	PERFORME	ED?	20 years 20 years 24b. WERE AUTOPSY FINDIN ANALLABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
	Sequentially list conditions, if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significent condition OTHYRO DID TOBACCO USE 25. WAS CASE REFERRED TO MEDICAL	DUE TO (DR AS A DUE TO (DR AS	A CONSEDUENCE OF): A CONSEDUENCE OF): Dut not resulting in the conseduence of the conse	DEATH Y 26. PL THER: Nursing Norm DF 28c. INJ	ZES NC ACE DF DEATH (C): 5 Raeldence	Part I. 24 1 Deck only one) 6 Other (S	PERFORME	ED?	24b. WERE AUTOPSY FINDING ANAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO		
	Sequentially list conditions, if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significent condition DID TOBACCO USE 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 ND 27. MANNER OF DEATH 1 Natural S Pending	b. CONCES. DUE TO (DR AS A DU	A CONSEDUENCE OF): A CONSEDUENCE OF): but not resulting in the conseduence of the conse	DEATH Y 26. PL THER: Nursing Nom DF 28c. INI. WO WO	TES NC ACE OF DEATH (C)	Part I. 24 1 Deck only one) 6 Other (S	PERFORME YES 2 X	ED?	24b. WERE AUTOPSY FINDING ANAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO		
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	Sequentially list conditions, if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significent condition PART II. Other significent c	b. CONCES. DUE TO (DR AS A DUE TO (DR	A CONSEDUENCE OF): A CONSEDUENCE OF): A CONSEDUENCE OF): Dut not resulting in the conseduence of the cons	DEATH Y 26. PL THER: Nursing Nom Note, factory, office at the time, data	TES NC ACE OF DEATH (C) 5 Residence URY AT RK? (ES 2 NO a	Part I. 24 1 Deck only one) 6 Other (S 26d. DESCR 26t. LOCATI City or 1	PERFORME YES 2 X Specify) NIBE HOW INJU ON (Street and fown, State)	I Number or R	20 ycans 24b. Were Autopsy Finding AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO		
	Sequentially list conditions, if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significent condition PART II. Other significent c	DUE TO (DR AS A DUE TO (DR AS	A CONSEDUENCE OF): A CONSEDUENCE OF): A CONSEDUENCE OF): Dut not resulting in the conseduence of the cons	DEATH Y 26. PL THER: Nursing Nom Note, factory, office at the time, data	Cause given in ZES NC ACE OF DEATH (C) TRY AT RK? AND AND AND AND AND AND AND AN	Part I. 24 1 Deck only one) 6 Other (S) 28d. DESCR 26t. LOCATI City or 1	PERFORME YES 2 X Specify) NIBE HOW INJU ON (Street and flown, State) (a) and manner d place, and d	URY OCCURE Number or R	20 ycans 24b. Were Autopsy Finding AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO		
	Sequentially list conditions, if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significent condition DID TOBACCO USE 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 ND 1 Natural 5 Pending Investigation 3 Suicide 8 Could not be determined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINE	DUE TO (DR AS A DUE TO (DR AS	A CONSEDUENCE OF): A CONSEDUENCE OF): A CONSEDUENCE OF): Dut not resulting in the conseduence of the cons	DEATH Y 26. PL THER: Nursing Nom Note, factory, office at the time, data	CES NC ACE DF DEATH (C) 5 Residence URY AT RK? (ES 2 NO and place, and due eath occured at the	Part I. 24 1 Deck only one) 6 Other (S) 28d. DESCR 26t. LOCATI City or 1	PERFORME YES 2 X Specify) NIBE HOW INJU ON (Street and flown, State) (a) and manner d place, and d	URY OCCURE Number or R	20 ycan S 20 ycan S 24b. WERE AUTOPSY FINDIN ANALLABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO ED Tural Route Number,		
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page 5 should be detached for use as the bunal-transit permit, Pages 1, 2, 3 should

ter death. Page 6 may be retained by the host	the funeral director, page 5 should be detache oval,	ai examiner must be notified at once.
TIN THE MINERAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 44 hours after death. Page 6 may be retained by the host	TO THE FUNEFAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached the filled with the State peor of Health and Mental Molene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE REGISTRAR	SIAIE UF IV			ICATE				MENTAL HYGIEN REG. NO					
	1. DECEDENT'S NAME (First, Middle, Last)				10/11/2	-			2. DATE OF DEATH			3. TIME OF DEATH		
- 8	GLORIA HOLI	OMAN							OCT. 22. 1995			7:01 PM		
	4. SOCIAL SECURITY NUMBER 5.	SEX 6. AGE (In yrs. last birthday,			IF UNDER 1	YEAR	IF UNDER	24 HRS.	7. DATE OF BIRTH		S. BIRTH	IPLACE (State or Foreign		
	237-78-6470	□ M 2 □XF	51	YRS.	MONTHS	DAYS	HOURS	MIN.	Oct 21,19	44	Nor	th Carolina		
	9e. FACILITY NAME (If not institution, give street	t and number)			9b. CITY, 1	TOWN C	R LOCATIO	ON OF DE			UNTY OF D	EATH		
8	PRINCE GEORGES HOSPITAL CENTER CHEVERLY PRINCE											E GEORGES		
DIRECTOR	RESIDENCE OF DECEDENT								-	1				
뿐	MD Prince	Coorgo!			ry, town on pital			3				10d. INSIDE CITY LIMITS?		
		George	5	- Cu	prodr							1 2 YES 2 NO		
18 I	10e. STREET AND NUMBER					101	ZIP CODE					WHAT COUNTRY?		
FUNERAL	1001 Glen Willow Dr						2074				J.S.A	•		
	1 Never Married 2 Married	FORCES? 1 IF YES, GIVE W	T EVER IN U.S. ARME YES 2 ANO AR OR DATES	ED	lf.	yes, sp		n, Maxica	IIC ORIGIN? (Specify Yen, Puarto Rican, atc.)	a or No	14. RACI Blaci Spec	E — American Indian, k, White, atc.		
В	3 Widowed 4 Divorced						Total Transport	ap 2 a,			-	Black		
8	15. DECEDENT'S EDUCAT (Specify only highest grade con		16a. DECE	EDENT'S	Work done du	CUPATIO	ON st of workin	α	16b. KIND OF BU	ISINESS/I	NDUSTRY			
	Elementary/Secondary (0-12)	College (1-4 or 5 +	•)		work done du ise retired.)				G					
COMPLET		+	Teac	ner					Govern					
	17. FATHER'S NAME (First, Middle, Last)								me (First, Middle, Meider es Darden	Surname)			
H	Eugene Moore													
2	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Juanita Merritt 19471 Cheryenne St. Detroit, MI. 48235													
	20a METHOD OF DISPOSITION 1 Burial 2 Cramation 3 Ramova		20b. PLACE AN				ime of		DATE 20c. L		— City or To			
	4 Donation 5 Other (Specify)	I from Stata	Church	l'o'Ce	meter	Y			19952 Harrellsville, N.C.					
	21. SIGNATURE OF FUNERAL SERVICE LICEN	SEE D	1.		22, N	AME A	ADDRES	SS OF FA	Funeral H	ome	e			
	* Vivawana	xX	Brax	10					Rd. Land		, MD 2	0785		
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate													
	shock, or heart fellure. List only one cause on each line. IMMEDIATE CAUSE (Finel Onset and Death													
	disease or condition resulting in death) a. Due to (or as a consequence of)													
	DUE TO (OR AS A CONSEQUENCE OF)													
Z	Sequentially list conditions, b. Dus to consciusion on													
Ĕ	if any, leading to immediate couse. Enter UNDERLYING	DUE TO	(OR AS A CONSEOU	ENCE (OF):									
일	CAUSE (Disease or Injury C	DHE TO	(OR AS A CONSEQU	IENCE (MED.									
Ē	that initiated events resulting in death) LAST	500 10	(OI) AS A CONSEGU	LIVOL	,. ,.									
CERTIFICATION	d													
	PART II. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED?													
OICA									1 1 TES			AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
MED												1 TYES 2 NO		
	DID TOBACCO USE CONTRIB	BUTE TO CA	USE OF DEAT	H Y	ES 🗆 N	10 E	1 UNC	ERTAI	N 🗆					
SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE	OF DE	ATH (Check o	-								
Sign		OSPITAL:	ER/Outpatient 3	DOA	4 Nursi		10 5 🗆 Ra	eldenca	6 Other (Specify)					
РНУ	27. MANNER OF DEATH	28e. DATE OF (Month, D		28b. TI	ME OF	28c. IN.	URY AT		28d. DESCRIBE HOW	INJURY (OCCURED			
ВУ	1 Natural 5 Pending 2 Accident Investigation	10/22	1	55			YES 2	NO	motor weh	ule	collis	in		
	3 Suicide 8 Could not be	28e. PLACE C building,	F INJURY — At hom etc. (Specify)	1		ory, offic	0		281. LOCATION (Street City or Town, State	and Num	ber or Rural	Houte Number, Hury		
	4 Homicide determined		5	tre	7				Landover	Mcl	7.77 60			
12		AN: To the best of	my knowledge, deat	th occur	red at the tir	me, date	and place	, end due	to the cause(a) and m	enner aa s	stated.			
COMPLETED	one) 2 X MEDICAL EXAMINER:	On the basis of a	xamination end/or in	veatigat	ion, in my op	pinion, d	leath occur	red at the	time, data and place, a	and due to	the cause(s) and manner as stated.		
Ü	29b. SIGNATURE AND TITLE OF CERTIFIER	1 1.					29c. LIC	ENSE NU	MBER			O (Month, Day, Year)		
00	Dennis	1. Che	ite mo				0.0	C.M	. E	1	OCT.	23,1995		
5	30. NAME AND ADDRESS OF PERSON WHO					ree	et .	Bal	timore,	Mars	zland	1 21201		
	DENNIS CHUTE MO 31. DATE FILED (MONTH) Day, Year)													
	OCT 26 1995	Jelian	AR'S SIGNATURED	dell										

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CERTIFICATION

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ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-729 11/27/95 t.t

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REGISTRAR'S SIGNATURE ha Dandson Randall

Pages 1, 2, 3 permit. burial-transit retained by the hospital or attending physician, as the nse be detached for Once. notified at page 5 should hours after death. Page 6 may be must be funeral director, examiner filled in by the fillion, or removal. medical ŏ the cremation. completely event, executed to burial, traumatic and physician requires that the death certificate be prior other attending p 0 the atten Mental F injury, and any Health a shows a Dept. of F HOSPITAL OR ATTENDING PHYSICIAN: The law th the State [d, or item item this c marked, DIRECTOR: After to hours after death v FUNERAL I = TO THE HOSPITA
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be filed within 7.

BALTIMORE, MARYLAND 21215-0020

BOX 6876

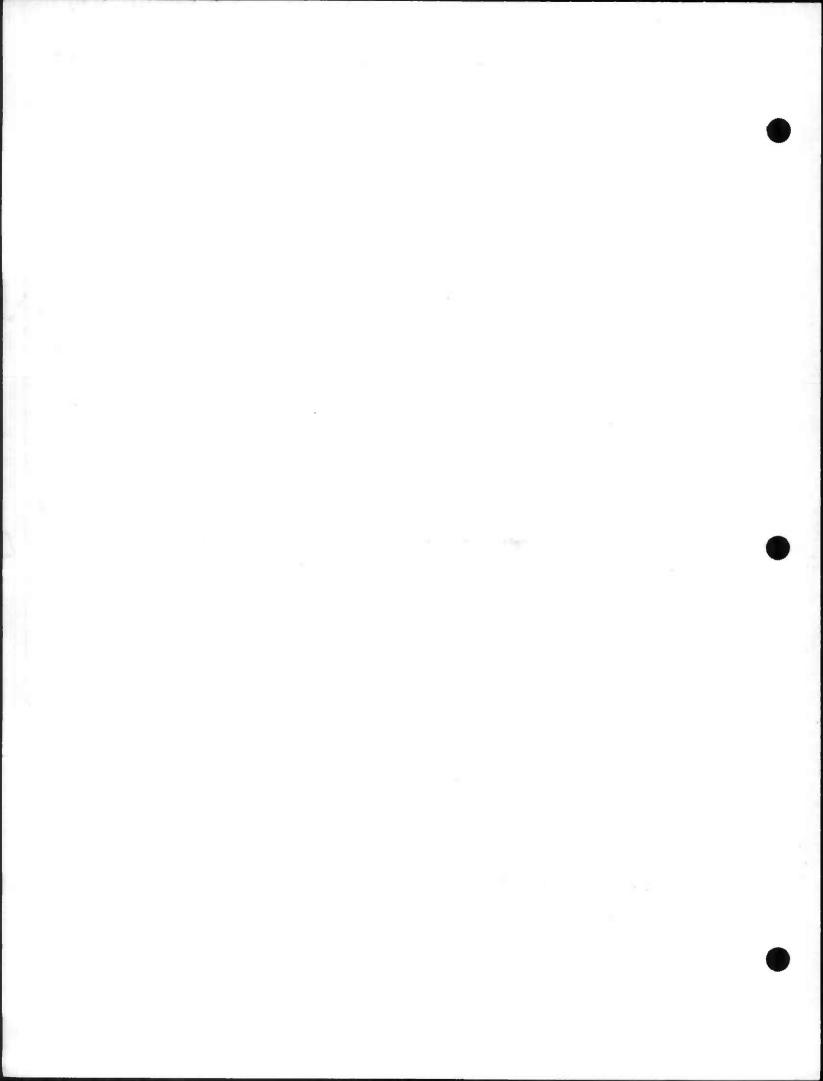
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RECORDS,

DIVISION OF VITAL

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2, DATE OF DEATH 3. TIME OF DEATH YEAR 9:55 PM THOMAS M. JONES NOV 995 JR 01 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. las) birthday) 7. DATE OF BIRTH (Month, Day, Year, Oct. 18, 5. SEX 8. BIRTNPLACE (State or Foreign IF UNDER 1 YEAR IF UNDER 24 HRS. 215-66-9614 HOURS 1 XX 2 □ F 39 1956 Maryland 9e. FACILITY NAME (If not institution, give etreet end number) 9c. COUNTY OF DEATH 9b. CITY, TOWN OR LOCATION OF DEATH DOCTOR'S HOSPITAL LANHAM PRINCE GEORGES RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10e. STATE 10b. COUNTY 10d. INSIDE CITY College Park Maryland Prince George's XX YES 2 NO 10e. STREET AND NUMBER 101. ZIP CODE 20740 10g, CITIZEN OF WHAT COUNTRY? 4908 Huron Street United States 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES XX NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-II yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. RACE — American Indian, Black, White, etc. Naver Merried 2 Merried 1 TYES XX NO Specify: White Specify 3 Widowed 4 Divorced 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Spe Elementary/Secondary (0-12) College (1-4 or 5 +) Postal Worker Untied States Postal Service 17. FATNER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Melden Surname) Thomas Milliren Jones, Sr. Helen T. Jones 19e, INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code, 20740 Timothy Talbert Jones 5127 Niagra Place College Park, Maryland 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE cedar H1111 Cemetery 11/4/1995 Suitland, Maryland 4 Donation 6 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill RD. Beltsville, Md. 20705 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, ahock, or heart failure. List only one cause on each line interval Batween **Onset and Death** IMMEDIATE CAUSE (Fine) disease or condition a. NARCOTIC INTOXICATION resulting in death) DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditiona, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF) that initiated eventa resulting in death) LAST PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS 24s. WAS AN AUTOPSY PERFORMED? AVAILABLE PRIOR TO COMPLETION DF CAUSE 1 TYES 2 NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\Boxed{1}\) NO \(\Boxed{1}\) UNCERTAIN \(\Boxed{1}\) 28. PLACE OF DEATN (Check only one) 25. WAS CASE REFERRED TO MEDICAL HOSPITAL 1 X YES 2 NO 1 Inpetient X XER/Outpetient 3 DOA 4 - Nursing Nome 5 - Residence 8 - Other (Specify) 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 27. MANNER OF DEATH 28b. TIME OF INJURY 28d. DESCRIBE NOW INJURY OCCURED 1 Natural 5 Pending Investigation FOUND PM FOUND: 11-1-95 1 YES 2XX NO UNKNOWN 2 Accident 26e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 4908 HARON STREET 3 Sulcide 6XX Could not be 4 Homicide FOUND: RESIDENCE COLLEGE PARK, MD. 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(e) end menner se stated. XXMEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(e) and menner so stated. 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) NOV. 2,1995 Roden 2 o.c.m.e 30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Milking HE-UDORE

Penn Street, Baltimore, Maryland 21201



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DIVISION OF VITAL RECORDS,	-
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THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 28 hours after death. Page 6 may be retained by the hospital or attending physician.

THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunal, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

	FOR	OTATE OF 144 DV						0 (, 5 , 5 0 0				
	1 - STATE REGISTRAR	STATE OF MARYL		ICATE OF		MENTAL HYGIEN REG. NO.							
	1. DECEDENT'S NAME (First, Middle, Last)		Tordan	1	2. DATE OF DEATH DO TO THE TOTAL DESTRUCTION OF THE TOTAL DESTRUCTION O	YEAR 95	3. TIME OF DEATH						
	4. SOCIAL SECURITY NUMBER 072-22-3847	5. SEX 8. AGE ((In yrs. lest birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH 8. BI (Month, Day, Year) Co			IIRTHPLACE (State or Foreign country)				
TOR	9a. FACILITY NAME (If not institution, give still SOUTHERN MORE) RESIDENCE OF DECEDENT	yland Husp	ntal	96, CITY, TOWN	OR LOCATION OF D	1//-	Pri	New York 9c, COUNTY OF DEATH PI'NCE OBJES					
DIRECTOR	10a. STATE 10b. COUNTY			Y, TOWN OR LOCA					10d. INSIDE CITY LIMITS?				
	CA LOS A	Angeles	Los	Angele	S CODE		40 00		1 X YES 2 NO				
HA	133 West 51st	Stroot			90037				HAT COUNTRY?				
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT EVER IN FORCES? 1 YES	2NO	If yes, s	CENDENT OF HISPA	NIC DRIGIN? (Specify Yea an, Puarto Rican, stc.)			— American Indian, White, etc.				
	3 Widowed 4 Divorced							Bla	ıck				
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12)	CATION completed) College (1-4 or 5+)	Ille. Do NOT us	work done during m se retired.)	ON ost of working	16b. KIND OF BUS		DUSTRY					
JMC	17. FATHER'S NAME (First, Middle, Last)		Domest	10	40 1107115010 11	Priv.							
	Cleveland Bigo	70			25111	Lina Tilla	,						
BE	19a. INFORMANT'S NAME (Type/Print)	10	19b. MAILING	ADDRESS (Street				o Codel					
5	William Jordan	The state of the s											
	20s. METHOD OF DISPOSITION 20b PLACE AND DATE OF DISPOSITION (Name of												
	Buriel 2 Cremation 3 Removal trom State 4 Donation 5 Other (Specify) Evergreen Cemetery 10/27/95 Brooklyn, N.Y.												
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Hodges and Edwards												
	Price Edward 3910 Silver Hill RD. Suitland, MD.												
	23. PART I. Enter the discesses, or co	pmolications that caused	t the death Do r	1 3 9 T U	SIIVer	HILL RD	.Suı	tlan					
	anock, or neert failure. L	List only one ceuse on si	ach line.	or enter the m	ode or dying, ad-	on as cerdiac or respi	ratury ar	reat,	Approximats Interval Between Onset and Death				
	immediate Cause (Finel disease or condition resulting in death)												
_		Severe	CONSEDUENCE OF	ro bras	1 hem	whage_			2 days				
은	Sequentially list conditions, If any, leeding to immediate	DUE TO (DR AS A	CONSEDUENCE OF	F):		Trage-			Ldays				
3	cause. Enter UNDERLYING CAUSE (Disease or Injury	Hypertens				> 5 47							
CERTIFICATION	that initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF	F):			_						
9	d	l							-				
- 1	PART II. Other significant conditions	contributing to deeth b	ut not resulting	in the underlyin	g ceuse given in				WERE AUTOPSY FINDINGS				
PHYSICIAN: MEDICAL						PERFOR			AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?				
W									1 YES 2 ND				
ž	DID TOBACCO USE CONTR	IBUTE TO CAUSE O	F DEATH YE	S I NO	UNCERTAI	N 🗆							
SIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE DF DEAT										
YSI	1 TYES 2 ND	1 Inpatient 2 ER/Outp	etlent 3 DOA	OTHER: 4 Nursing Hor	ne 5 🗆 Rasidence	8 Other (Specify)							
	27. MANNER OF DEATH 1 Netural 5 Pending	28s. DATE OF INJURY (Month, Day, Year)	28b. TIM INJ	URY W	JURY AT DRK? YES 2 ND	28d, DESCRIBE HOW INJURY OCCURED							
COMPLETED BY	2 Accident Investigation 3 Suicide 8 Could not be determined	28e. PLACE OF INJURY building, stc. (Spec	— At home, term, s			281. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
٦	29a. CERTIFIER 1 X CERTIFYING PHYSIC	CIAN: To the best of my knowl	ledge death con-	ad at the time at-	and place and the	to the occupate.		44.4					
ME		R: On the basis of examination							and manner on stated				
- 1	29b. 900 TURE AND THE OF CERTIFIER	4 4 4		,, opiniott,	,								
H	MANAGE AND THE BOTH CENTIFIER	2 411			29c. LICENSE NU	MBER	29d. DAT	E SIGNED	Month, Day, Year)				
၉	30 NAME AND ADDRESS DE REPRON MONO	COMPLETED CAUSE OF DE			Vage	Jos W		10	12/42				

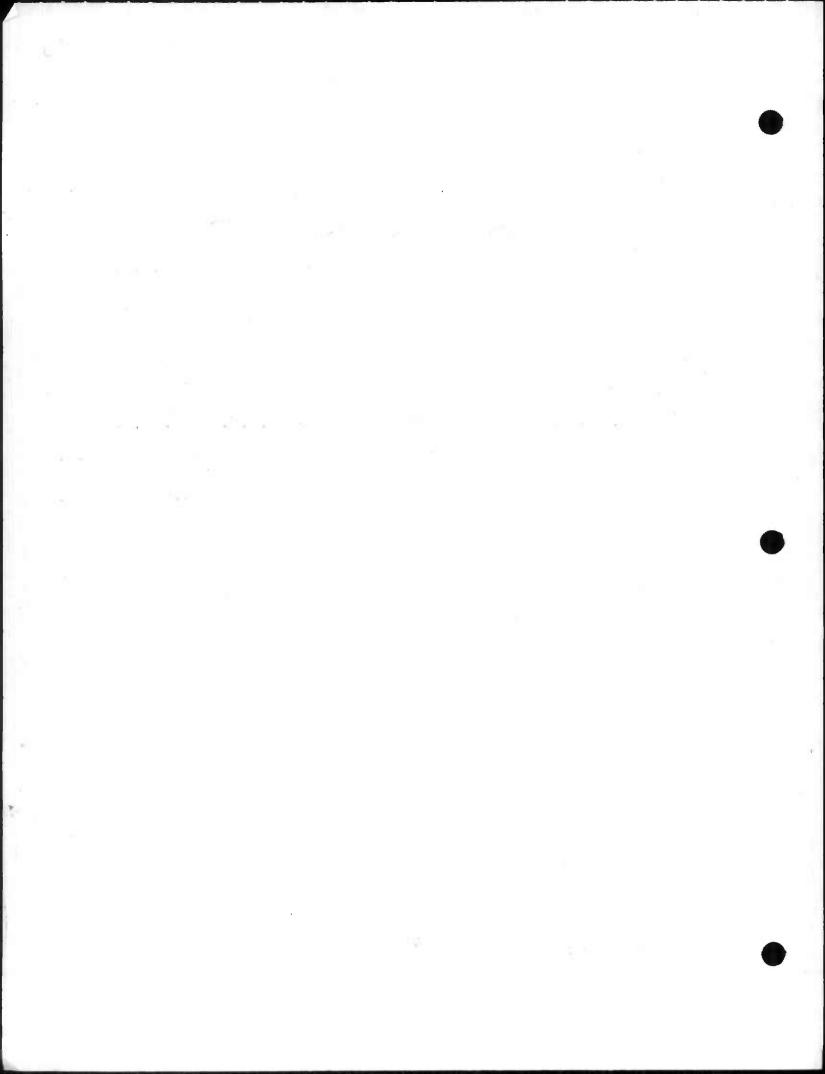
ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

M. L. Marsclas M.D., 9440

32 REGISTRAR'S SIGNATURE

Sharon L.

OCT 25 1995



Pages 1, 2, 3 should

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attend	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as is		ce.
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Де 6 п	irector,		r mus
death. Pa	funeral d		examine
hours after	d in by the	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunal, cremation, or removal.	IMPORTANT: If Nem 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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31. DATE FILED (Month, Day, Year)

031995

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH REG. NO 1, OECEDENT'S NAME (First, Middle, Last) 2. DATE OF OEATN 3. TIME OF OFATH OCTOBER 1995 LAWRENCE 11:35Pm **JACKSON** 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year 6. AGE (In yrs. lest birthday) IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign Country) DAVE HOURS 579-76-1713 1 X M 2 F 39 Oct. 55 Wash Sa. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR P.G. Hospital Cheverly P.G. RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY P.G. YES 2 NO Md. Landover 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 1107 Capital View Dr. 20746 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 NO IF YES, GIVE WAR OR DATES WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No— If yea, specify Cuban, Mexican, Puerto Rican, etc.) 1) Never Married 2 Married 1 YES 2X NO Specify: Specify: 3 Widowed 4 Divorced

FUNERAL United States 14. RACE — American Indian, Black, White, etc. BY Black **Black** 8 15 DECEDENT'S EQUICATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KINO OF BUSINESS/INDUSTRY (Specify only high (Give kind of work done life. Do NOT use retired.) Ш Elementary/Secondary (0-12) College (1-4 or 5+) COMPL 12 Clerk rivat 17. FATNER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Meiden Surname) Melvin Bullard Maryetta R. Jackson 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING AODRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Melvin Bullard 1107 Capital View Dr. Landover, Md. 20746 20s. METHOD OF DISPOSITION
1 □ Burial 2 X Cremation 3 □ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State OATE Va. Crematory 11-2-95 Arl. Va. 4 Donation 5 Other (Specify). 21. SIGNATU TO FUNERAL SERVICE LICENSEI 22. NAME AND ADDRESS OF FACILITY Capitol Mortuary 1425 Maryland Ave., N.E. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23. PART I. Enter the diseases, or comp Approximata Intarval Between IMMEDIATE CAUSE (Finsi Onset and Death diseese or condition Respirator Assest mmiduate resulting in death) DUE TO OR AS A CONSEQUENCE OF) HOPOXIA CERTIFICATION Sequentistly list conditions. DUE TO (OR AS A CONSEQUENCE OF) if sny, lesding to immediate cause. Enter UNDERLYING Gram (1) Sepsis CAUSE (Disesse or Injury DUE TO (OR AS A CONSEQUENCE OF) thet initiated events resulting in desth) LAST TERMINAL AIDS, Agranulo cytopenia, AMS 1ears PART II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL I.V. Doug MAILABLE PRIOR PERFORMED? abuser COMPLETION OF CAUSE OF DEATH? 1 - YES 2 1 NO 1 | YES 2 | NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 🗷 PHYSICIAN: 28. PLACE OF DEATN (Check only one) 25. WAS CASE REFERRED TO MEDICAL OTHER: 1 YES 2/1 NO 1 1 Inpetient 2 ER/Outpetient 3 DOA 4 ☐ Nursing Nome 5 ☐ Residence 8 ☐ Other (Specify) 27. MANNER OF DEATN 28a. DATE OF INJURY 28b. TIME OF INJURY 28c. INJURY AT NA 28d. DESCRIBE NOW INJURY OCCUREO 1 Natural 5 Pending MAN AM 1 YES 2 NO NA BY 2 Accident Investigation 28s. PLACE OF INJURY — At home, farm, street, fectory, office building, etc. (Specify) t and Number or Rural Route Number 3 Suicide 28f. LOCATION (Stre City or Town, St 8 Could not be determined ED 4 Homicide NA NA COMPLET 29a. CERTIFIER

1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of exemin . SIGNATURE AND TITLE OF CERTIFIER KAMAL J. MOHAN, M.D 29c. LICENSE NUMBER 29d, DATE SIGNED (Month, Day, Year) 出 leamastinaher (D46822 10/19/95 MEDICAL RESIDENT)

ISS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

MOHAN, MID. P.G. HOSP CTR, 3001 HOSP Dr., Cheverly STRAR'S SIGNATURO

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Administration of

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

REG. NO.

	- 1	1. DECEDENT'S NAME (First	Middle Lest									1 0 0175	E DEATH		T	- THE OF ST	
		, , , , , , , , , , , , , , , , , , , ,		L. Irv	. Irving King							2. DATE OF DEATH DAY OCTOBER 27,1995 3. TIME OF DEATH 4:30 P					
		4. SOCIAL SECURITY NUMBER	BER	5. SEX 6. AGE (in yrs. lest				IF UNDER	24 HRS.	7 DATE O	7 DATE OF BIRTH		e BIRTHIN ACE (Come or Comition				
		217-36-692	7	1 3 M 2 F		1	YRS.	MONTHS	DAYS	HOURS	MIN.	June	26,19	2/1	Country)	ryland	
pinou		90. FACILITY NAME (If not in		treet end number)				9b. CITY	, TOWN	OR LOCATION	ON OF DE		,-/		ITY OF DE	-	
2, 3 should	OR			en eral H	ospi	tal			(Olney				Mo	ntgon	nery	
	5	RESIDENCE OF DEC		I son CIT	Y, TOWN C	28 1 004	TION					T.					
permit. Pages	DIRECTOR	Maryland	tgomery			106. (4)	i, lown c	_	mascu	S					LIMITS? X		
ermit.	AL [10e. STREET AND NUMBER		ogo.noz y				10	r. ZIP CODE				10a. CITI		IAT COUNTRY?		
늏	ER/	11411 Kingstead Rd.								208	72					tates	
215-0020 attending physician. se as the burial-transit	FUNER	11. MARITAL STATUS	12. WAS DECEDEN	IT EVER I	N U.S. ARI	MED	MED 13. WAS OECENDENT OF HISP It yes, specify Cuban, Mexi						or No-	14. RACE -	- American Indian, White, etc.		
00 pg ag	ВУ	©©XNever Merried 2 ☐ 3 ☐ Widowed 4 ☐ Divo		IF YES, GIVE						S 2 CNO	Specify		con, mc.)		Specify	White	
15-0 ttending	ED	15. DEC	EOENT'S EDU	CATION		16e, DE	CEDENT'S	USUAL O	CCUPATI	ON		165	KIND OF BUS	INESSTIND		AUT CB	
2121 al or att	Ш	(Specify only Elementary/Secondary (0	y highest grade 0-12)	College (1-4 or 5	+)	(GI	ve kind of	of work done during most of working use retired.)				100.			OJINI		
AND the hospital detached to once.	COMPL			2	2		Far	mer					Farmi	ng			
AND the hospit detached once.	Ö	17. FATHER'S NAME (First, M								16. MOTH			ddle, Melden				
RYL ad by	BE (C. King									M. Bea				
MAR retained 5 should notified	2	19. INFORMANT'S NAME (7) B. Jane				19b							SCUS			72	
E, De page		20a. METHOD OF DISPOSIT			200	DIACEA	-	OFDISPOS	_		114.9			CATION — (
BALTIMORE, MARYLAND 21215-0020 after death. Page 6 may be retained by the hospital or attending physic by the funeral director, page 5 should be detached for use as the burial noval. cal examiner must be notified at once.		120 Buriel 2 Cremation 4 Donation 5 Other	(Specify)	oval from State	cen	petery, crei	netory or o	ther plece)	Bap	tist	10/3	31/95	Ce			e, Md.	
TIN Page ral dir		21. SIGNATURE OF FUNERA	L SERVICE LIC	ENSEE		4		22.	NAME A	ND ADDRES	S OF FA	CILITY					
AL. death fune fune exam		Olin L. Molesworth, P.A. 26401 Ridge Rd., Damascus, Md. 20872										20872					
by by		23. PART I. Enter the diseases, or complications that caused the death. Do not enter tha mode of dying, such as cardisc or respiratory arrest. Approximate															
		IMMEDIATE CAUSE (Finel A Onget and E											Interval Between Onget and Death				
thin 24 tely fille mation.		disease or condition a. Aucun q										16 mg					
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So to to to to to to to to to to to to to	RTIFICATION	if sny, lesding to immed csuse. Enter UNDERLY	ING		,		.02/102 0	, ,.									
certificate ding physiene pri	Ĕ	CAUSE (Disease or Inju that initiated events		OUE TO	(OR AS	CONSEC	UENCE O	F):					_				
e Hith	CERT	resulting in death) LAS	' L.	1													
E Me de		PART II. Other significe	nt condition	s contributing to	death b	out not re	euiting	in the un	derlyln	g ceuse g	Iven in	Part I.	24a. WAS AN	AUTOPSY	24b. V	VERE AUTOPSY FINDINGS	
	AEDICAL	PART II. Other significent conditions contributing to death but not resulting in the underlying couse of								PERFORMED?				AWAILABLE PRIOR TO COMPLETION OF CAUSE			
1 3 0 E S	MEC													10		OF GEATH?	
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N: The lav ficate has State Dep	YSICIAN:	25. WAS CASE REFERRED TO EXAMINER?	O MEDICAL	HOSPITAL:		26. PLAC	E OF DEAT	OTHER	-								
F VIT SICIAN: The certificate the State the State	1 XS	1 YES 2 NO		1 Impatient 2		patient 3		4 🗆 Nun	ling Hon		sidence	6 🗆 Other					
NG PHYSIC fler this ce sath with th	H	1 Natural 5	Pending	26e. DATE OF (Month, D			26b. TIM INJ	URY M	WC	JURY AT ORK? YES 2	I NO	28d. DEŞC	RIBE HOW IN	IJURY OCC	URED	- 1	
ON VOING Affer death	BY	2 0 0 1-14	Investigation	28e. PLACE C	F INJURY	/ — At hor	ne, term, :	street, fact			NO	26f, LOCAT	TION (Street e	nd Number	or Rural Bo	tte Number	
2 E E E 2	TED		Could not be determined	bullding,	etc. (Spec	cffy)							Town, State)			,	
	7	290. CERTIFIER	IFYING PHYSI	CIAN: To the best of	my know	riedge, des	rth occum	ed at the ti	me, date	and place	end due	to the coun	e/e) and man	par sa state	vd.		
Z 22 = L (Check only												end manner ea stated.					
E HO	ш	296. SIGNATURE AND TITLE	OF CERTIFIER							29c. LICE	NSE NUN	BER	T	29d. DATE	SIGNED (A	Aonth, Day, Year)	
TO THE HOSPIT TO THE FUNERA DE filed within 7 IMPORTANT: 1	D 10690 D 10690 D 10690 D 10690 D 10690 D 10690 D 2076 LGR 28 D 10690 D 2076 LGR 28 D 10690 D 2076 LGR 28 D 10690 D 2076 LGR 28 D 10690									R 28, 1995							
	F	30. NAME AND ADDRESS OF	PERSON WHO	COMPLETED CAU	SE OF DE	ATH (ITEM		11		CI D		10				/	
31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE																	
		POT 3	31. DATE FILED (MORTH, Day, 1907) 32. REGISTRAR'S SIGNATURE 32. REGISTRAR'S SIGNATURE 34. REGISTRAR'S SIGNATURE 34. REGISTRAR'S SIGNATURE 35. REGISTRAR'S SIGNATURE														

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HE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death cartificate be executed within A hours after death. Page 6 may be retained by the hospital or attending physician.		filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunal, cremation, or removal.	IPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HOS	TO THE FUN	be filed with	IMPORTAN

	FOR STATE OF MAR 1 - STATE REGISTRAR			F HEALTH AND	MENTAL HYGIENE REG. NO.	E	
1	1. DECEOENT'S NAME (First, Middle, Lest)				2. DATE OF DEATH		3. TIME OF OEATH
,	JOS	SEPH LE	E Kno	tts	Oct. 29	,1995	4:06 PM
		GE (In yrs. leat birti			7. DATE OF BIRTH (Month, Day War)	0.	BIRTHPLACE (State or Foreign
1	220-09-1024 1 🛮 M 2 🗆 F	80 v	'RS, MONTHS D	AYS HOURS MIN.	APRIL 4,19	915 M	ARYLAND
_	9a. FACILITY NAME (If not institution, give street and number)			WN OR LOCATION OF O	EATH	9c. COUNTY	
<u> </u>	MEMORIAL HOSPITAL AT EASTON			EASTON		TAL	BOT
DIRECTOR	10a. STATE 10b. COUNTY	10	c. CITY, TOWN OR	OCATION			10d. INSIDE CITY LIMITS?
_	MARYLAND DORCHESTER	H	IURLOCK				1 TYES 2 X NO
FUNERAL	10e. STREET AND NUMBER	Po		10f. ZIP CODE			OF WHAT COUNTRY?
NE I	4864 SKINNERS RUN ROAD 11. MARITAL STATUS 12. WAS DECEDENT EV	FORD		21643			USA
	1 Never Married 2 Married II. Was december in Forces? 1 1 Never Married II. Was december in Forces? 1 1 Never Married II. Was december in Forces?	ES 2 NO	If y	e, specify Cuban, Maxical YES 2 X NO Specific		or No- 14.	. RACE — American Indian, Black, White, atc.
B	3 🔀 Wildowed 4 🗌 Olvorced	H DAIES	''	YES 2 [X] NO Specif	y.		Specify: WHITE
	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	(Give ki	ENT'S USUAL OCCI		16b. KIND OF BUS	INESS/INDUS	TRY
LET	Elementary/Secondary (0-12) College (1-4 or 5+)		NOT use retired.) S CLERK		RETAIL.	HARDWA	ARE STORE
COMPL	17. FATHER'S NAME (First, Middle, Last)	DILLE	OBBIAC	18. MOTHER'S NA	AME (First, Middle, Maiden		210113
Ŭ	JEROME KNOTTS				SELLERS		
0 8	19e. INFORMANT'S NAME (Type/Print)				Route Number, City or Town	n, Stere, Zip Co	de)
F	ELISABETH PARKER	Ρ.	O. BOX 1	80, HURLOC			
	20a. METHOD OF DISPOSITION 1 X Buriel 2 Cremation 3 Removel from State		DATE OF DISPOSITI	CEMETERY			or Town, State
	4 Donation 5 Other (Specify)	LAST NEW		ME AND ADDRESS OF FA		NEW M	MARKET, MD
	* Langual De	1100	ZELI	LER FUNERAL	HOME, P.		
_	23. PART I. Epter the diseases, or complications that ca	uned the death					KET, MD 21631
	shock, or heart failure. Liet any one cause of		, DO HOT BINGS II	e mode of dying, add	on the cartinet of the pri	ratory arroad	interval Between Onest and Death
	IMMEDIATE CAUSE (Finel disease or condition pauliting in death)	c ovres	1				MINUTES
	Todatting in doubtil	AS A CONSEQUE					
z	Sequentially list conditions, b. CO7000		my dy	ase.			YEARS
CERTIFICATION	if any, leading to immediate cause. Enter UNDERLYING	AS A CONSEQUE	NCE OF):	7			YEARS
윤	CALISE (Disease or Inluny	AS A CONSEQUE	NCE OF):	are			ICAR
	reaulting in death) LAST						
	PART II. Other eignificent conditions contributing to dee	th but not reau	Iting in the unde	riving ceuse given in	Part I. 24a, WAS AN	AUTOPSY	24b, WERE AUTOPSY FINDINGS
CAL				, , , , , , , , , , , , , , , , , , , ,	PERFOR		AVAILABLE PRIOR TO COMPLETION OF CAUSE
						Mino	OF DEATH?
2	DID TOBACCO USE CONTRIBUTE TO CAUS	E OF DEATH	YES N	UNCERTAI	NX		
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		F DEATH (Check on	y one)			
YSI	1 TYES 2 NO 1 Inpetiant 2 KER		DOA 4 - Nursin	g Home 5 🗆 Realdence			
	27. MANNER OF DEATH 28a. OATE OF INJ (Month, Day, Y	JRY 28 bar)	Ib. TIME OF 2	Bc. INJURY AT WORK?	28d. DESCRIBE HOW II	NJURY OCCUP	RED
BY	2 Accident Investigation 28s. PLACE OF IN	JURY — At home,	farm, street, lector		281, LOCATION (Street a	and Number or	Rural Route Number,
	3 Succes 6 Could not be building, atc. 4 Homicide determined	(Specify)			City or Town, State)		
E	29a. CERTIFIER Check only CERTIFYING PHYSICIAN: To the best of my	knowledge, death	occurred at the tim	e, data and place, and du	e to the cause(a) and mar	nner as stated.	
COMPLET	one) 2 MEDICAL EXAMINER: On the beals of exami	nation and/or inve	stigation, in my opi	nion, death occured at the	e Ilme, data and placa, en	nd due to the c	cause(a) and manner as stated.
	29b. MATURE AND LULE OF CERTIFIER			29c. LICENSE NU	MBER	29d. DATE S	SIGNED (Month, Day, Year)
TO BE	Calalan MA			052	395	10	130/95
-	CHRISTINE L. GALAN, M.D., 2			CTON CTDET	T FACTON	MD 21	601
	31 DATE FILED (Month Day Year) 32 49004TRA03			GION SIKEE	I, EASTON,	TID ZI	OOT
	31. DATE FILED (Month, Day, Year) 1995	min ward	all with				

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withing hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEDENT'S NAME (First	Middle, Last)								2. DATE	OF DEATH		I	3. TIME OF DEATH
	Charles Ed	ward K	ing							MONT		W 18. 1	YEAR	10 10 m/M
	4. SOCIAL SECURITY NUME	BER	5. SEX	6. AGE (In yrs. I	lest birthday)	IF UNDER	R t YEAR	IF UNDER	1 24 HRS.	7. DATE	OF BIRTH	ر ما	S. BIRTH	12:10 PMM PLACE (Stete or Foreign
	_579-03-897	7	1 X M 2 - F	85	YRS.	MONTHS	DAYS	HOURS	MIN.		h, Day, Year) . 28, 19	110	Country	ew Jersev
	9e. FACILITY NAME (If not in					9b. CITY	r, TOWN C	R LOCATI	ON OF DE		20, 1.		INTY OF DI	
OR	Washington Adventist Nursing Center Takoma Park Montgome											erv		
DIRECTOR	RESIDENCE OF DECEDENT													
H	Maryland Prince George's Cheverly												10d. INSIDE CITY LIMITS?	
												1 X YES 2 NO		
BY FUNERAL	100. CITIZEN OF WHAT											HAT COUNTRY?		
N.	11. MARITAL STATUS	venue	12 WAS DECEDEN	T EVED IN II C	Burn	1 10			_				.A.	
E	1 Never Married 2	Thed 2 Married FORCES? 1 YES 2 NO If yes specify Cuben for Newton Rican, Reverto Rican, etc.)										, White, etc.		
	3 Widowed 4 Divo	rced	IF IES, GIVE Y	MIN ON DATES			1 TES	2 M NO	Specin	y:			Specif	w White
COMPLETED	15. DEC	EDENT'S EDUC	CATION COMPONENT	16a. E	ECEDENT'S	USUAL O	CCUPATIO	ON .		168	. KIND OF BU	SINESS/IN	DUSTRY	
	Elementary/Secondary (0		College (1-4 or 5	+)	'Give kind of w fe. Do NOT us	e retired.)	ounny mo	SI OF WORK	ng					
MP	12			Me	tal L	athe	r				Carpent	ers	Unio:	n
8	17. FATHER'S NAME (First, M							18. MOT	HER'S NA	ME (First,	Middle, Meiden	Sumame)		
H	Charles W.										ller_			~
2	190. INFORMANT'S NAME (7										ber, City or Tow			
	Charlene :				_				Che		y, Md			
	1 DBuriel 2 Cremetlo	n 3 🗆 Remo	oval from State	cemetery c	rematory or ot	har place I				DAT	_		City or Tox	
	4 Donation 5 Other 21, SIGNATURE OF FUNERA		ENSEE	- Fort	Linco	In C	emet	ery	SS OF FA	2/21/	95 B1	entw	ood.	Md. 20722
		> 1									ns Fur	eral	Home	e - 4739
_	W. 1	5.6	Perie			Ва	1tim	ore	Ave.	, Hy	attsvi	11e,	Md.	20781
	23. PART i. Enter the di shock, or he	iseases, or c eart failure. I	omplications that List only one cau	it ceused the c use on each iir	faath. Do n ne.	ot enter	the mo	de of dy	ing, suci	h as can	diac or respi	ratory ar	rest,	Approximats Interval Between
	IMMEDIATE CAUSE (Fin									_				Onset and Death
- 1	resulting in death)	→ ,	Dehydra DUE TO	tion du	e to	beni	gn e	soph	agea	al st	rictu	re .		
S O	Sequentially list conditi	ons,	Coronar	Y Arter	y Dis	ease				_				
CERTIFICATION	If any, leading to immed cause. Enter UNDERLYI	NG	Carcino			,								
Ĕ	CAUSE (Disease or inju that initiated events	γ) '		(OR AS A CONS):								
E	resulting in death) LAS	Т	1,											
- 11	PART II. Other significa	nt conditions	e contribution to	death but not	essulting t	n the con	ada akala -		and the	200				
MEDICAL				douth but not	resuming i	ii tiie ui	laeriying	cause i	Alagu itt	Part I.	24a. WAS AN PERFOR		-	WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION DF CAUSE
										- 1	1 TYES 2	₩ NO		OF DEATH?
~ 1	DID TOBACCO U	SE CONTR	DIRLITE TO CA	LISE OF DE	ATU VE	<u>. </u>	NO E	LINIC	EDTAIN					1 TES 2 NO
A	25. WAS CASE REFERRED TO		OBOIL TO CA		CE OF DEAT			DINC	EKIAII	и Ц				
SIC	EXAMINER? 1 ☐ YES 2 🔯 NO		HOSPITAL:			OTHER	R:			. C				
PHYSICIAN:	27. MANNER OF DEATH		28e. DATE OF	INJURY	28b. TIME	OF	28c. INJU	JRY AT	sidence	8 Othe	CRIBE HOW I	JURY OC	CURED	
BY P		Pending Investigation	(Month, D	Pay, Year)	INJU	JRY M	1 Y	RK? ES 2	NO					
	2 D 2-1-14:	Could not be	28e. PLACE O	OF INJURY — At h	ome, ferm, s	treet, fact	tory, office			281. LOC	ATION (Street e	nd Number	or Rural Re	oute Number,
		determined	ounding,	etc. (Specify)						City	or Town, State)			
ן ב	29e. CERTIFIER (Check only	IFYINO PHYSIC	CIAN: To the best of	my knowledge, d	leath occurre	d at the t	lme, date	end place	and due	to the cau	ree(e) and man	ner es ste	led.	
COMPLET														end menner ee stated.
	296. SIGNATURE AND TITLE								NSE NUN					Month, Day, Year)
BE	Sur	& au	36					D14					0/19/	
2	30. NAME AND ADDRESS OF	PERSON WHO	COMPLETED CAUS	SE OF DEATH (III	MET) (Type,	Print)							-1 - 21	
	Dr. Suresh	C. Gup	ta, M.D.	3503 P	erry :	Stre	et,	Mt.	Rain	ier,	Maryl	and	207	12
- 1							_							
	31. DATE FILED (Month, Day,	tear)	23/REGISTRA	R'S SIGNATURE	roball									
	OCT 2	5 1995	Jaha 10	R'S SIGNATURE	rdall									- 6



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BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunal, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MARYLA		TMENT OF I		MENTAL HYGIEN						
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH			TIME OF OEATH			
1 8	JAMES M. K	(IELY Jr	•			October !		EAR D	12:05 AM M			
		5. SEX 8. AGE (III	yrs. last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH		BIRTHPL/ Country)	ACE (State or Foreign			
	9a. FACILITY NAME (If not institution, give stre			9b. CITY, TOWN	DR LOCATION OF D		7-16-35 Cambridge					
Mandia Cardens Center LANDAM Prince RESIDENCE OF DECEDENT 100. STATE 100. COUNTY Prince CREATER 100. COLLY, TOWN OR LOCATION Prince CREATER 100. CITY, TOWN OR LOCATION												
IRE(10a. STATE 10b. COUNTY	A	10c, CITY, TOWN OR LOCATION 10d.									
	100. STREET AND NUMBER	Georges	1 3	10	. ZIP CODE		10g. CITIZEN	OF WHA	YES 2 NO			
FUNERAL	3706 Idols	stone U	the		20719	5	L	15				
	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT EVER IN FORCES? 1 X YES	2 NO	If yes, sp	ecify Cuban, Maxico	NIC ORIGIN? (Specify Year, Puerto Rican, etc.)	s or No- 14.	RACE — Black, W	American Indian, hite, atc.			
Э ВУ	3 Widowed 4 Divorced	IF YES, GIVE WAR OR DAT			2 XNO Specif	y:		Specify:	white !			
COMPLETED	15. OECEDENT'S EOUCA (Specify only highest grade co	ompleted)	16a. DECEDENT'S (Give kind of v life. Do NOT us	vork done durina mi	ON est of working	Brown . W			arborough			
APLE	Elementary/Secondary (0-12)	College (1-4 or 5+)		Consul	tant	& Quinn		0,50	arboroug			
Sol	17. FATHER'S NAME (First, Middle, Last)				16. MOTHER'S NA	ME (First, Middle, Maiden	Sumame)					
BE (James M. Kiely Si				Anita	Houle						
2	19a. INFORMANT'S NAME (Type/Print) Joan Kiely			Address (Street and Idolsto		Route Number, City or Tov Bowie Mar		207	15			
	20a. METHOD OF DISPOSITION	20b.	PLACE AND DATE O				CATION - CHY					
	t ∯ Buriet 2 ☐ Cremation 3 ☐ Remove 4 ☐ Donation 5 ☐ Other (Specify)	al from State ceme	tery, crematory or of	ther place)			owie Ma		The state of the s			
	21. SIGNATURE OF FUNERAL SERVICE LICEN	ISEE			ND ADDRESS OF FA	CILITY						
	Kovert E.	Cuans	Mea			ans Funera Lis Rd. Bo						
	23. PART I. Enter the diseases, or conshock, or heart fallure. Lie	mplications that caused	the deeth. Do n	ot enter the mo	de of dying, suc	h ss cardiac or resp	iratory srrest	,	Approximats Interval Between			
	IMMEDIATE CAUSE (Finel disease or condition	, , , , , , , , , , , , , , , , , , , ,	vii tirigi.						Onsst and Death			
	resulting In desth)	METASTATIC	COLON (CANCER					~10mo			
Z	Compatibility lies and data at b.	HEPATIC IN	ISVFFICE	ENCY					~ 2 wks			
A	Sequantially list conditions, if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A	CONSEQUENCE OF	7):								
FI	CAUSE (Disesse Dr Injury that initiated events	OUE TO (OR AS A	CONSEQUENCE OF	j:								
CERTIFICATION	resulting in death) LAST											
	PART II. Other significant conditions	contributing to death by	t not resulting i	n the underlyin	ceuse given in	Pert I. 24a, WAS AN	VALITORSV	24h WE	RE AUTOPSY FINDINGS			
ICAL	SEIZURE DISORDER					PERFO	RMED?	AM	AILABLE PRIOR TO MPLETION OF CAUSE			
MED	AORTIC VALVE RE		secondar	u to ENI	DOCARDIN		E BO NO	6.5	DEATH?			
N.	DID TOBACCO USE CONTRI	BUTE TO CAUSE OF	DEATH YE	S INO								
PHYSICIAN: MEDIC		HOSPITAL:	6. PLACE OF DEAT	H (Check only one) OTHER:								
HYS	1 YES 2 NO 1 27. MANNER OF DEATH	28a. DATE OF INJURY	tlent 3 DOA 28b. TIM			8 Other (Specify) 28d. DESCRIBE HOW	IN JURY OCCUR	ED.				
ВУ Р	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	LNI	M 1	RK?	ave. Degombe from						
	3 Suicide 8 Could not be	28s. PLACE OF INJURY - building, stc. (Specif	- At home, farm, s	treet, factory, offic		281. LOCATION (Street City or Town, State		iural Floute	Number,			
	4 Homicide determined											
COMPLETED		AN: To the best of my knowle										
8		On the basis of exemination	and/or investigation	n, in my opinion, c			nd dua to the co	use(s) an	d manner as stated.			
띪	296. SIGNATURE AND TITLE OF CERTIFIER	2111.m	0.1:)	M.D.	29c. LICENSE NUI			1	onth, Day, Year)			
임	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEA	TH (PTEM 27) (Type,	Print)	D44	176	10	19 9	>			
	14300 Gallant	Fox lane #	118 Ba	wie. M	20719	,						
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNA	TURE		<u> </u>		-					
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30. NAME AND ADDITION

31. DATE FILED (Month, Day, Year)

25 1995

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 1995 Anton October 22, Kragh 8:45 P. 7. DATE OF BIRTH (Month, Day, Year) 9/17/11 6. AGE (In yrs. last birthday) 4 SOCIAL SECURITY NUMBER 5. SEX BIRTHPLACE (State or Foreign Country) 231-05-0359 1 M 2 F 84 MONTHS DAYS HOURS MIN. Colorado Se. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Pineview Manor Extended Care Facility Clinton DIRECTOR Prince George's RESIDENCE OF DECEDENT 10d. INSIDE CITY Maryland Prince George's Forest Heights 1 X YES 2 NO 10e. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? tor. ZIP CODE FUNERAL 104 S. Huron Dr. 20745 USA 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 YES 2 NO Specify: 11, MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 14. RACE — American Indian, Black, White, etc. FORCES? 1 X YES 2 LE YES GIVE WAR OR DATES WWII USMC 1 Never Married 2 Married BY S Widowed 4 Divorced White COMPLETED 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade Elementary/Secondary (0-12) 12th College (1-4 or 5+) Retired Police Officer D.C. Government 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Nicholin G. Kragh Agnes Walborg Petersen 19a, INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Patricia M. Kragh same as item 10 20g. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE 20g. METHOD OF DISPOSITION

1 (N) Buriel 2 Competition 3 Removal from State
4 Donation 5 Other (Specify)

21. BIGHATURE OF UNERAL SERVICE LICENSEE Cedar Hill Cemetery 10/26/95 Suitland, Md. 22. NAME AND ADDRESS OF FACILITY
George P. Kalas Funeral Home also 6160 Oxon Hill Rd. Oxon Hill, Md.20745 23. PART I. Enfer the diseases, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death **IMMEDIATE CAUSE (Finel** My apoller protion disessa or condition resulting in death) CERTIFICATION Sequentially list conditions, OR AS A CONSEQUENCE OF) If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEDUENCE OF) that initiated evente resulting in death) LAST PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PHYSICIAN: MEDICAL AVAILABLE PRIOR TO COMPLETION DF CAUSE 1 TES 2 NO OF DEATH? 1 YES 2 ND DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES 🗷 NO 🗌 UNCERTAIN 🗍 26. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL OFHER:
4 A) Nursing Home 5 - Residence 6 - Other (Specify) 1 VES 2 XNO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 28a. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 26b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED t X Natural 5 Pending 1 YES 2 ND BŸ Investigation 2 Accident 28e. PLACE OF INJURY — At home, farm, street, lectory, office building, etc. (Specify) 3 Sulcide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 4 Homicide Ē 29e. CERTIFIER (Check only one)

2 MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and menner as attend. COMPL 2 MEDICAL EXAMINER: On the basis of exemination and/or investigation, in my opinion, and due to the ceuse(e) end manner as stated. 29b. SIGNATURE AND TITLE OF 29d. DATE SIGNED (Month, Day, Year) 29c. LICENSE NUMBER BE ▶Oct. 23, 1995

6188 Oxon Hill Rd. Oxon Hill, Md. 20745

Frank M. Ryan, M.D. 32 REGISTRAR'S GIGNATURE

COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

water rains to the

* 3/ 3/

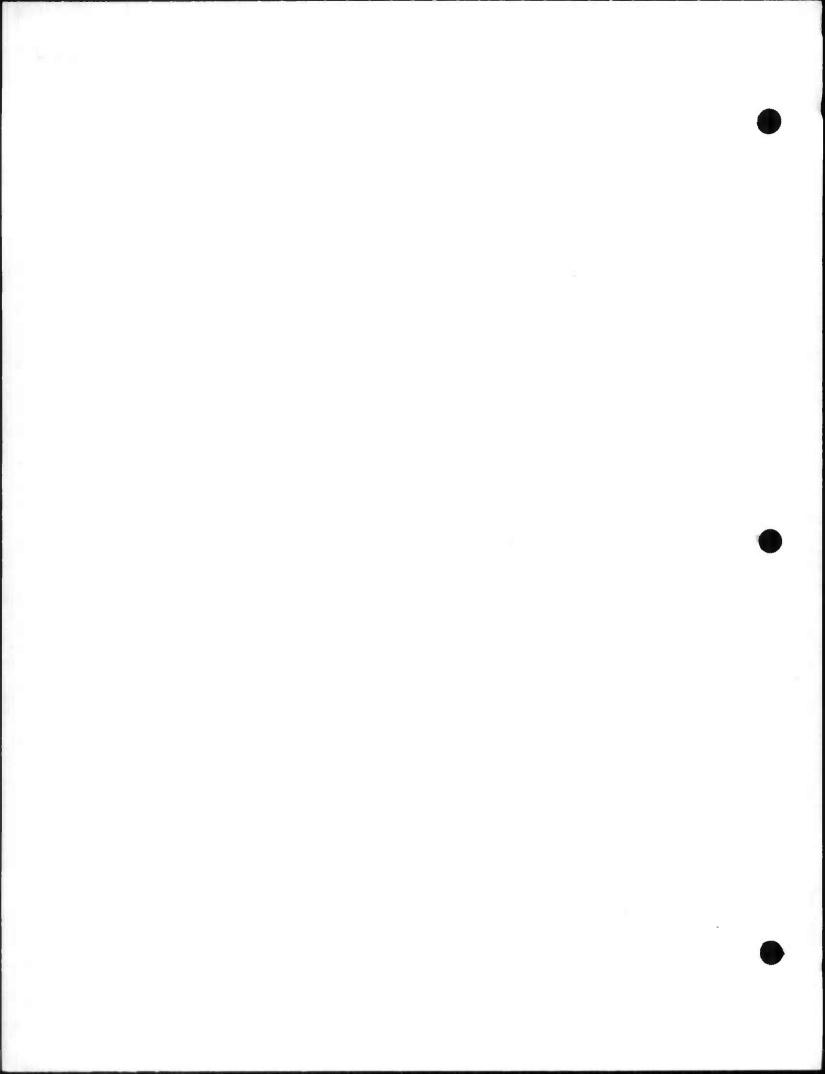
			1 - FOR STATE REGISTRAR	STATE OF MARYL		TMENT OF I		MENTAL HYGI REG.					
			1. DECEDENT'S NAME (First, Middle, Lest					2. DATE OF DEAT			TIME OF DEATH		
				ZABETH LI	SENBE	7-		OCT.		YEAR	7:30 A		
	Pir		4. SOCIAL SECURITY NUMBER 579–10–1723	1 - M 2 KF	(In yrs. lest birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Yea May 8	1912	Country)	ACE (State or Foreign		
	2, 3 should	TOR	90. FACILITY NAME (If not institution, give CALVERT ME RESIDENCE OF DECEDENT	morial H	OSPITAL		OR LOCATION OF I		9c. COUNT		ERT		
	. Pages 1,	DIRECTOR	10a. STATE 10b. COUNT	Calvert	10c. CIT	Y, TOWN OR LOCA	natown						
	permit.	AL	10e. STREET AND NUMBER				r. ZIP CODE		10g, CITIZE		T COUNTRY?		
	1St	ER	2551 Hunting	Creek Road			2063	19		U.S.	Α.		
215-0020	as the burial-transit	BY FUNER	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2 NO	If yes, sp	CENDENT OF HISP/ pecify Cuben, Mexic 3 22 NO Spec	ANIC ORIGIN? (Specify an, Puerte Rican, etc.	Yes or No- 14				
21215	nse	ETED	15. DECEDENT'S ED (Specify only highest gred	le completed)	16a. DECEDENT'S (Give kind of w life. Do NOT us	vork done during me		16b. KIND OF	BUSINESS/INDUS	_	WILLCE		
ND 2	De Co	3	Elementary/Secondary (0-12)	College (1-4 or 5+)	Home	maker		Our	1 Home				
AND S	detached for once.	COMPLET	17. FATHER'S NAME (First, Middle, Lest)		110/110	menter	18. MOTHER'S N	AME (First, Middle, Ma					
7 3	8 8	ш	Osia L. Sim	ms			Lott	ie		D	avis		
MARYLA	5 should notified	0 8	19a. INFORMANT'S NAME (Type/Print)		196. MAILING	ADDRESS (Street	and Number or Rura	Route Number, City or	Town, State, Zip C	ode)			
2	9e 5	۴	Patricia Warn	er	2521	Hunting	Creek R	oad Hunt	ingtown	, MD	20639		
ш ,	- g -		20a. METHOD OF DISPOSITION 1 □ Burlel 2 ※ Cremetion 3 □ Rer	noval from State 20b.	PLACE AND DATE O	F DISPOSITION (N	ame of	DATE 20c	LOCATION - CIT	y or Town,	State		
Page 6 mg			4 Donation 5 Other (Specify) 21. SIGNATURE/OF FUNERAL SERVICE L		etropoli	tan Cre	matory 1	0-30-95	Alexand	ria,	VA.		
ALTI			21. SIGNATURE OF FUNERAL SERVICE L	ICENSEE /			ND ADDRESS OF F						
BA			Lay	111		Rause	ch Funer	al Home,	PA Owi	ngs,	MD 2073		
within 74 hours a	ompletely filled in by the cremation, or remove event, the medical		23 PART I. Enter the dispessa, openhock, or heart feliure iMMEDIATE CAUSE (Final disease or condition resulting in death)	a. ACUTF	ach lina.	MIA	ode of dying, au	ch aa cardiac or re	apiratory arrea	t,	Approximate interval Between Onset and Death Ower Two WEEKS		
LOX 587	cian and coor to buria	RTIFICATION	Sequentially list conditions, if any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): d.										
S, P.O. Bodeath certificate	the attending phy Mental Hygiene I Ijury, or other	CERTIFIC											
L MECOMDS, law requires that the des	H W H	MEDICAL	PART II. Other algnificant condition BR FAST AND	UTFRWE	ut not resulting in		g ceuse given in	PER	S AN AUTOPSY FORMED?	AM CO	ERE AUTOPSY FINDINGS AILABLE PRIOR TO MPLETION OF CAUSE DEATH?		
ME	been sign. of He	M		RICLATION						1{	YES 2 NO		
1 8	has be Dept.	A	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL					N 🗆 📗					
VIIAL	cate 1 State	PHYSICIAN:	EXAMINER?	HOSPITAL:	28. PLACE OF DEAT	OTHER:							
P <	the the	¥ I	1 YES 2 AO	1 Inpatient 2 ER/Outp	atlent 3 DOA 26b, TIME		ne 5 Residence	6 Other (Specify)					
5 £	fter this cath with		1 Natural 5 Pending	(Month, Day, Year)	INJU	URY WO	YES 2 NO	28d. DEŞCRIBE HO	W INJURY OCCUP	NEU			
ATTENDING PHYSICIAN: The	DIRECTOR: After nours after death tem 28 is mai	COMPLETED BY	2 Accident Investigation 3 Suicide 8 Could not be determined	28e. PLACE OF INJURY building, atc. (Speci	— Al home, farm, s			281. LOCATION (Str. City or Town, St		Rural Route	» Number,		
2 8	DIREC hours item	۳	290. CERTIFIER 1 TO CERTIFYING PHYS	IICIAN: To the best of my knowl	adaa daath aanum	d of the time date	and alone and de-						
PITAL	로ピ≡	M I		ER: On the basis of examination							od manner en eteted		
THE HOSPITAL	TO THE FUNER be filed within IMPORTANT:		296. SIGNATURE AND TITLE OF CENTIFIE				29c, LICENSE NU						
	APOR APOR	BE	1 Hz # 5	resol in				-0	29d, DATE S	IGNED (Mo	onth, Day, Year)		
2	28₹	2	30. NAME AND ADDRESS OF PERSON W	10 COMPLETED CAUSE OF DEA	ATH (ITEM 27) (Type.	Print)	1263	0	1.00	, 0	9,1995		
	(// - 1	I 602 Mg			FOREIC	KIMD- 8	20678				
	9		31. DATE FILED (Month, Day, Year) OCT 3 1 199	32. REGISTRAR'S SIGNA	ATURE	- //	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	- 11 -1)	-				
	L		001 9 T 188) Have a minus	" waroung	<u></u>							

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HE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	HE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1. 2. 3 should	led within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial. cremation, or removal.	ORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at ence.
TO THE	TO THE	be filed	IMPOR

	ended# 9b, FOR 1 - STATE REGISTRAR	10/31	/95, S STATE OF N	W, Ca MARYLAN	ID / DEP	ARTME	NT OF H			MENTAI	L HYGIENI REG. NO.	E			
	1. DECEDENT'S NAME (First, ANDREW	Middle, Last)]	LATVA	LA		-		2. DATE	OF DEATH	26	1995	11:00	- M
	4. SOCIAL SECURITY NUMB 528-48-42		5. SEX 1 🔀 M 2 🗌 F	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			ER I YEAR DAYS	IF UNDER	24 HRS. MIN.	7. DATE (Month Mar	of BIRTN 1, Day, Year) 26, 1	939	8. BIRTNP Country)	MI	n
OR	3930 CH		et and number) LLE RD	•		9b. C	XAUC	R LOCATION	OW OF DE	INGS	5	ČÁĽ	VÉRT	NTN	
DIRECTOR	10a. STATE	10b. COUNTY			10c.	CITY, TOW	OR LOCAT	'ION					1	IOd. INSIDE CITY	
	MD	C	alvert			Ow	ings							YES 2 X NO	
FUNERAL	3930 Chane	eyville	Road				101	20 ZIP CODE	736			10g. CITI		A.	
BY FUN	11. MARITAL STATUS 1 Never Merried 2 3 Uldowed 4 Divo	Married	12, WAS DECEDEN FORCES? 1 IF YES, GIVE V	YES	2 NO	1	If yes, sp		in, Maxicai	n, Puerto I	i? (Specify Yes Rican, atc.)	or No—	14. RACE - Black, Specify	- American Indian, White, atc. White	
C3.	15. DEC (Specify onl)	EDENT'S EDUCA y highest grade o	ATION ompleted)	_10	Ba. DECEDEN	T'S USUAL	OCCUPATION OCCUPATION	ON ast of working	na	16b	. KIND OF BUS	BINESS/INC	USTRY	WILLCO	
COMPLETED	Elementary/Secondary (C		College (1-4 or 5 +		Ilfe. Do NO	T use retired	1.)			1 F	ed. Go	v't	H.U.	D.	
00	17. FATHER'S NAME (First, M	liddle, Last)			T - L-	1-					Widdle, Maiden	Sumame)	T - 1- t	-1-	
BE	Walfred 19a. INFORMANT'S NAME ((ma/Print)		·	Laty		SS /Stand o		Helm		ber, City or Town	e Ctata Tie	Leht	:01a	_
2	Carma Laty										ings,		20736		
	20a, METHOD OF DISPOSIT 1	ION on 3 🗆 Remov	val from State	cemete	LACE AND DA	TE OF DISP	OSITION (No	ime of		DAT	E 20c. LO	CATION —	City or Tow	n, Stata	2
	4 Donation 5 Dother (Specify) Metropolitan Crematory 10+29-9\$ Alexandria, 21. SIGNATURE OF PUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Rausch Funeral Home PA Owings.														
	shock, or heart fallure. List Dniy one cause Dn each line.											Approximate interval Bette Onset and E	поем		
CERTIFICATION	Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):														
PHYSICIAN: MEDICAL CE	PART II. Other algnifica					ng in the			given in		24a. WAS AN PERFOR	MED?	NT.	WERE AUTOPSY FIND MAILABLE PRIOR TO COMPLETION OF CAL OF DEATH? 1 YES 2 NO	ISE
IAN	25. WAS CASE REFERRED T	_		26	PLACE OF										
YSIC	1 XYES 2 NO		HOSPITAL:		ent 3 🗆 DC	A 4 🗆	ER: lursing Non	10 5 XR	asidence	6 🗆 Othe	er (Specify)				
	27, MANNER OF DEATH 1 Natural 5	Pending		Day, Year)		TIME OF INJURY	W	JURY AT ORK?	7.00	26d, DE	SCRIBE HOW I	NJURY OC	CURED		
ED BY	2 Accident	Investigation Could not be determined	28a. PLACE (26-65 OF INJURY — etc. (Specify	- At home, fe	rm, street,		YES 2	_ NO		CATION (Street or Town, State)		or Rural Ro	oute Number,	
Success 8 Could not be determined building, etc. (Specify) 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basis of axamine from and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s)										and manner as stat	ed.				
BE	29b. SIGNATURE AND TITLE	OF SERTIFIER	Je.	1					. C . M			29d. DAT	TOBI	Month, Day, Year) ER 27,1	995
10	30. NAME AND ADDRESS O	F PERSON WHO	OW ler	ISE OF DEAT	111	Type, Print) Pen	n St	ree	t, E	Balt	imore	, Mā	ryla	and 212	01
	31. DATE FILED (Month, Day, Your) OCT 3 1 1995 Juli Davelen-Randall														

	_	1 - STATE REGISTRAR	STATE OF	MARYL			ICATE				MENTAL	REG. NO.	E			
		1. DECEDENT'S NAME (First, Middle	Last)								2. DATE	OF DEATH	W	YEAR	3. TIME OF DEATH	
		Winifred	E. Lagan	a							C	ct. 2	6. 1	995	1 - 1 4 A W	
		4. SOCIAL SECURITY NUMBER	5. SEX	8. AGE	(In yrs. leat bi	irthday)	IF UNDER		IF UNDER		7. DATE	OE BIRTH		a. BIRTH Country	PLACE (State or Foreign	
D		213- 24-3125	1 🗌 M 2 💢 F	1	67	YRS.	MONTHS	DAYS	HOURS	MIN.	Marc	h 5,	1928	Mary	land	
should		9a. FACILITY NAME (If not institution	, give atreet and number)				9b. CITY	TOWN O	R LOCATI	ON OF DE						
2,3	CTOR	Doctors	Hosptial				Lā	ınhan	n				Prir	nce G	eorge's	
- S	ш		COUNTY			10c. CIT	Y, TOWN C	R LOCAT	ION						10d. INSIDE CITY	
Pages	DIA.	Maryland Pr	rince George	e's			Jpper			0					LIMITS?	
permit.	AL.	10e. STREET AND NUMBER							ZIP COD		_		10a CITI	ZEN OF W	HAT COUNTRY?	
	1 %	0002 Ca	I downed to						207						States	
020 physician. burial-transit	FUNER	11. MARITAL STATUS	ldenrod Las	NT EVER II	N U.S. ARME	D	13.	WAS DECI			IIC OBIGIN	? (Specify Yes				
5-0020 nding physician is the burial-trau		1 Never Married 2 Married	FOROGOO	1 YES	2 XNO		- 1	f yes, spe	cify Cube	n, Mexica	n, Puerto F		0.1.0		— American Indian, , Whita, atc.	
affing the	B	3 Wildowed 4 Divorced	11 120, 0172	THIS ON D	HILD			☐ TES	² XNO	Specify	,			Specif Whi		
215-0 attending use as the	0	15. DECEDENT (Specify only highes			16a. DECE	DENT'S	USUAL O	CCUPATIO	N		16b.	KIND OF BUS	SINESS/INC		16	
- 8 - C	1	Elementary/Secondary (0-12)	College (1-4 or 5	+)	ille. Do	NOT u	work done (se retired.)	during mos	it of worldr	g	1,000					
S & C	, E	12	2	_	Real	tor	•				R	eal Es	state			
4 e e	COMPL	17. FATHER'S NAME (First, Middle, Li	nst)						18. MOT	HER'S NA		fiddle, Malden				
84	ы	Harvey	Ferguson							7	lma	Llovd				
MAR retained 5 should		19a. INFORMANT'S NAME (Type/Prin			19b. N	AAILING	ADDRESS	(Street ar	nd Number			er, City or Towi	n, State, Zip	Code)		
		Bruce A. Lagan	a		86	05	Pert	h La	ne,	Clir	ton,	Md 207	735			
L ~ @ .	2	20a, METHOD OF DISPOSITION		20b	. PLACE AND	DDATE	OF DISPOS	ITION /Na	ne ol -	-L 0	O BATE	95 20c. LO	CATION —	City or Tox	wn, State	
Age 5 m	100	1 🔯 Burial 2 Cremation 3 C 4 Donation 5 🗀 Other (Specif)		Cen Cen	etery, crema dar H	tory or o	ther place)	eter	٠, ر	CT 2	8,19	95 Sui	tlan	d. M	đ	
Page al direc		21. SIGNATURE OF FUNERAL SERV	ICE LICENSEE			1000	22.	NAME AN	DADDRE	SS OF FA	artife	e Fune	ral	Home	Inc 6633	
ALLIMOR death. Page 6 ma s funeral director, p	CASIME	14 4 50 To	1				01	d Al	exan	dria	Fer	ry Roa	d. C	linto	on Md	
		23 DADTA Enter the disease	or complications th	*********	4 44											
5 5 .	Tiencal Cal	23. PART . Enter the disease shock, or heert fa	liure. Liet only one ce	use on e	ach line.	i. Do i	10t enter	tne mod	se or ay	ng, suci	n as card	lac or respi	ratory arr	est,	Approximate interval Between	
filled ion, or		IMMEDIATE CAUSE (Final disease or condition	11/2-	1	-100			has		1-1	1	,			Onset and Death	
etely emat		disease or condition Third degree heart block 2 De condition Third degree heart block												2 Days		
ed w	5		A CUC	O (OR AS A	CONSEDUE	ENCE O	7.1	2000	,	10	- 0				many	
executed and com	NOI	Sequentially list conditions, Due to (OR AS A CONSEQUENCE OF):										years				
ior to	F	If any, leading to immediate cause. Enter UNDERLYING	use Enter UNDERLYING USE (Disease or Injury C. Rheumatoid Arthr, 45										11			
phys phys	음	CAUSE (Disease or Injury														
Ser Central	CERTIFICATION	that initiated events resulting in death) LAST	05	Osteomy elites Chronic												
			d. 00							110	NIC					
2 E E	CAL C	PART II. Other aignificant con						derlying	cause	lven in	Part I.	24a. WAS AN		24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO	
the the		Kecen	t Suptic	. Le	++ k	< NI	ee				_	1 TYES 2			COMPLETION OF CAUSE OF DEATH?	
v requires the been signed it. of Health	: MEDI												Λ		1 YES 2 NO	
L L L L L L L L L L L L L L L L L L L		DID TOBACCO USE CO	ONTRIBUTE TO CA	AUSE O	F DEATH	1 YE	S 🗆 I	KI ON	TINC	ERTAIN	1 🗆					
	SICIAN:	25. WAS CASE REFERRED TO MEDIC EXAMINER?			26. PLACE C	OF DEAT		-								
SICIAN: The Series of the State	YSI	1 TYES 2 TO NO	HOSPITAL:	☐ ER/Outp	atient 3 🗆	DOA	OTHER		5 🗆 Re	sidence	8 🗆 Other	(Specify)				
PHYSICIA this certif	. 7	27. MANNER OF DEATH	28a. DATE D (Month,	F INJURY	2	86. TIM	E OF	28c. INJL	PRY AT		28d. DEŞ	CRIBE HOW IP	JURY OCC	CURED		
or this	ВУ Р	1 Netural 5 Pending 2 Accident Investig		ITA	-		M		ES 2	NO						
NOING I. After r death	2 0	3 Suicide 8 Could n	28s. PLACE	OF NJURY	- At home,	, ferm, s	street, fact	ory, office				TION (Street a	nd Number	or Rural A	oute Number,	
OR ATTENDING DIRECTOR: After hours after death	o III	4 Homicide detarmi		, etc. (oper	anyy						City o	r Town, State)				
P. Dan	LE E	29a. CERTIFIER 1 X CERTIFYING	PHYSICIAN: To the best of	f my know	ledge dagth	occum	ad at the ti	me dete	and pince	and due	to the carr	note) and man		-4		
7 70 .	-1 🛎 1		AMINER: On the state of												and manner as stated	
TO THE HOSPITA TO THE FUNERA be filed within 7		296. SIGNATURE AND TITLE ON GE	1150													
물 물 물	E H	1.5								NSE NUN			29d. DATI	SIGNED	(Mogth, Day, Year)	
223		30, NAME AND ADDRESS OF PERSO	ON WHO COME ETER CAL	ISE OF OF	ATM NYCA:	T) (7:-	Deleth.		MD 1	0079	44		-10	121	173	
		Seth Lourie, M						~1±	MA	207	70					
		31. DATE FILED (Month, Day, Year)	22 DEGISTO	OVET	ELMA	, G.	recin	ETT,	MA	207	/ U					
		OCT 3 1 1	995 Julia	A SIGN	MOUS RO	1.11										
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BALTIMORE,	4
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1 - FOR STATE REGISTRAR

		1 - FOR STATE REGISTRAR	STATE OF MARYLAN		TMENT OF			GIENE 3. NO.			
		1. DECEDENT'S NAME (First, Middle, Lest) Gladys Webb Lect					2. DATE OF DE	ATH DAY	YEAR	3. TIME OF DEATH	
		4. SOCIAL SECURITY NUMBER	•	- ford high doub			October	10	1995	0300	
P)		061-07-4150	1 □ M 2 X F 90	rs. lest birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	HOURS MIN.	7. DATE OF BIR (Morith, Day,) October	(bar)	Countr	PLACE (State or Foreign rgia	
, 2, 3 should	DIRECTOR	90. FACILITY NAME (If not institution, give The Kent & Queen A		Inc.		ertown	DEATH	ec. cou Kei	nty of d	EATH	
Pages 1.	l m	10a. STATE 10b. COUNT	TY	10c, CITY	, TOWN OR LOC	ATION			- I	10d. INSIDE CITY	
permit. Pa	RAL DIF	Maryland 100. STREET AND NUMBER	Kent			ertown		10e, CIT	ZEN OF Y	t XYES 2 □ NO	
. FS	113	233 Richard Driv	ve .			21620				tates	
5-0020 inding physician. as the burial-transit	BY FUN	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U. FORCES? 1 YES 2 IF YES, GIVE WAR OR DATE:	NO	If yes, s	CENDENT OF HISPA specify Cuben, Mexic is 2 X NO Speci	en, Puerto Ricen, e	Ify Yes or No-	14. RACE Black Speci	— American Indian, c, White, etc.	
r attending use as the	03	15. DECEDENT'S ED		a. DECEDENT'S	USUAL OCCUPAT	TON	16b. KIND	OF BUSINESS/INC		ite	
spital or ed for u	PLET	(Specify only highest grad	College (1-4 or 5+)	Homake		nost of working		stic / (Homo	
the hospit detached	COMPL	17. FATHER'S NAME (First, Middle, Lest)		TROMETRO		18. MOTHER'S NA	AME (First, Middle, I		JWII I	TOTIC	
retained by the S should be continued at a	ш	Alfred W. Hill				Mamie	Holmes				
retained 5 should anotified	2	19e, INFORMANT'S NAME (Type/Print)				RESS (Street end Number or Rural Route Number, City or Town, State, Zip Code)					
4D 40		Britt LeCompte	20h Di	ACEANDDATEO				oc. LOCATION -			
age 6 ma director.		20a. METHOD OF DISPOSITION 1	noval from State cemeter	y, crematory or oth	her place) — Or	tober 10,	1995	over, De			
Page		21. SIGNATURE OF FUNERAL SERVICE L	CENSEE /	Dal	22. NAME A	AND ADDRESS OF FA	ACILITY		LEWICEC		
ter death. Puth the funeral wal.		William L. H	King Jr. Jh			ows Funer est High St			Marvi	land 21620	
in by reme			complications that caused the List only one cause on each	e death. De n	ot anter tha m	oda of dylng, suc	ch as cardiac or	respiratory sn	est,	Approximate Interval Between	
% € 6 5		iMMEDIATE CAUSE (Final disesse or condition	Ca	p + +	5/1/00	-				Onset and De	
P 50 50		resulting in death)	DUE TO (OR AS A CO	NSEQUENCE OF	iii					2040	
3 ° 0 E	CATION	Sequentially list conditions, if any, leading to immediate	b DUE TO (OR AS A CO	NSEQUENCE OF):						
e by car	5	CAUSE (Disease or Injury	c DUE TO (OR AS A CO	NSEOLIENCE OF							
ding the series	CERTIFIC	that initiated events resulting in death) LAST		NSECUENCE OF);						
the death the attent d Mental P	뜅	DADT II Other significant and disc	o							1	
- 26 -	8	PART II. Other aignificant condition	ns contributing to death but r	not reaulting in	tha underlylr	ng cause given in		AS AN AUTOPSY ERFORMED?	24b.	WERE AUTOPSY FINDIN AVAILABLE PRIOR TO	
requires that seen signed of Health a	MEDIC						1 🗆 ነ	ES 2 NO		OF DEATH?	
he law requires has been sign a Dept. of Healt at 23 shows	2	DID TOBACCO USE CONT	RIBUTE TO CAUSE OF D	DEATH YES	S \square NO Γ	UNCERTAI	N 🗆			1 NES 2 NO	
9 2 2	SICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26.	PLACE OF DEATH	H (Check only one						
SICIAN: The certificate the State	YSI	1 TES 2 DATO	HOSPITAL: 1. Inpatient 2 - ER/Outpatient		OTHER: 4 - Nursing Ho	me 5 🗆 Residence	8 Other (Specif	y)			
子語書	PHY	27. MANNER OF DEATH 1. Return 5 Pending	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME INJU	IRY W	JURY AT ORK?	28d. DESCRIBE	HOW INJURY OCC	URED		
After death	ВУ	2 Accident Investigation 3 Suicide & Could not be	28e. PLACE OF INJURY —	At home, ferm, et		YES 2 NO	281 LOCATION (Street end Number	ov Purel D	Inustra Muserbay	
OR ATTENDING DIRECTOR: Atter hours after death tem 28 is ma	TED	4 Homicide 8 Could not be determined	building, etc. (Specify)		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Town,	State)	or norm n	oute Namoer,	
DIR	l m l	290. CERTIFIER 1- CERTIFYING PHYS	ICIAN: To the best of my knowledg	e, death occurred	at the time, dat	e end place, and due	to the cause(s) or	rd manner en stet	ad		
HOSPITAL FUNERAL Within 72	COMPL		ER: On the basis of exemination en							end menner as stated	
TO THE HOSPITAL TO THE FUNERAL Be filed within 72 IMPORTANT: II	w	29b. SIGNATURE AND TITLE OF CERTIFIE	R			29c. LICENSE NU	MBER	29d. DATI	SIGNED	(Month, Day, Year)	
5 5 3 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	TO B		mann			D005	354		1 1	10195	
	-	30 NAME AND ADDRESS OF PERSON WI	M D	(ITEM 27) (Type.	Print)		mi	21/ ~			
	0	31. DATE FILED (Month, Day, Year)	32. REGISTRAT'S SIGNATUR	RE	ICOTCI	1000)	1110.	21620			
	i\ep/ ∥	1	and in a sign Al Ul	-							

Julia Davidson-Randall

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTA	L HYGIENE
CERTIFICATE OF DEATH	REG. NO.

	FOR 1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPART	MENT OF H	EALTH AND	MENTAL HYG					
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEA	ГН		3. TIME OF DEATH	Α	
	Dorothy Elizabe	th Loller				Septembe	r 27	1995	0345	M	
	4. SOCIAL SECURITY NUMBER	Tries and the second		F UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7 DATE OF BIOT	м	0. BIRTHP	LACE (State or Forek	gn	
	217-80-4764		83 YRS.			August 10	, 1912	Mary	land		
OB	90. FACILITY NAME (If not institution, give street and number) The Kent & Queen Anne's Hospital Inc. Chestertown MD Kent Residence of Decement										
5	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY			TOWN OR LOCAT			1 1/1/21			=	
L DIRECTOR	Maryland 10. STREET AND NUMBER	Kent	100.011,	Worton					10d. INSIDE CITY LIMITS?		
FUNERAL	10811 Worton Road			101	21678			rizen of wi	HAT COUNTRY?		
F	11. MARITAL STATUS	12. WAS DECEDENT EVER IN		13. WAS DEC	ENDENT OF HISPA	NIC ORIGIN? (Speci an, Puerto Rican, et	ly Yee or No-		- American Indian, White, etc.		
BY I	1 Never Married 2 X Married 3 Widowed 4 Divorced	FORCES? 1 YES	ITES X		2 NO Speci		C-)	Specify	r	- 1	
	15. DECEDENT'S EDUC	ATION	16e. DECEDENT'S U	SUAL OCCUPATION	·M	165 KIND O	E BUONIECO III	Whit	te	_	
COMPLETED	(Specify only highest grade of Elementery/Secondary (0-12)	College (1-4 or 5+)	(Give kind of wo	rk done during mo	st of working	166, KIND O	F BUSINESS/IN	DUSTRY			
1PL	7	College (1-4 or 5+)	Storeke	eper		Gre	cery I	Busine	ess		
S	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	AME (First, Middle, M	elden Sumame)				
BE (Charles Ivens				Mae U	silton					
2	Mr. Dan Loller					Aoute Number, City of			21678		
	20s. METHOD OF DISPOSITION 1A Burlel 2 Cremation 3 Remon	20h	PLACE AND DATE OF				c. LOCATION -		,	улаг	
	t& Buriel 2 ☐ Cremation 3 ☐ Remort 4 ☐ Donation 5 ☐ Other (Specify)	vel from State	etery, cremetory or other	ry - Sep	tember 29.	1995 O	esterto				
	21. SIGNATURE OF FUNERAL SERVICE LICE	NSEE	00	22. NAME AN	D ADDRESS OF FA	ACILITY					
	William L. King Jr. 413 West High Street, Chestertown, Maryland 21620										
	23. PART i. Enter the diseases, pr co shock, pr heart failure. L	emplications that disused	the death. Do no	t enter the mo	de of dying, aud	ch as cerdiac or	reapiratory a	rest,	Approximata		
	IMMEDIATE CAUSE (Final	ist billy blie cease on a	on the						Onset and D		
	disease or condition resulting in deeth)	DUE TO (OR AS A	atomy	Pailu	re_						
2	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A	CONSEQUENCE OF):	010					+	\dashv	
8	cause. Enter UNDERLYING CAUSE (Disease or injury	TO BAC	co ABu	al_							
F	that initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF):								
CERTIFICATION	d.									_	
AL	PART II. Other aignificant conditions	contributing to death be	ut not reaulting in	the underlying	cause given in	Part I. 24a. W	S AN AUTOPSY		WERE AUTOPSY FINDS	NGS	
8	HISP, ASCHO	MALNAU	us had	HOM	nxiele	1 U VI	ES 2 NO		COMPLETION OF CAU	SE	
PHYSICIAN: MEDIC								1	YES 2 NO		
AN	DID TOBACCO USE CONTR				UNCERTAI	N 🗆					
S	EXAMINER?	HOSPITAL:		OTHER:							
HYS	27. MANNER OF DEATH	1 ☑ Inpetient 2 ☐ ER/Outp	28b. TIME			8 Other (Specify 28d. DESCRIBE H		CURED			
	1 Natural 5 Pending	(Month, Day, Year)	INJUI	WO WO		200. DESCRIBE I	OW INSURT OC	CONED			
р Вү	2 Accident Investigation 3 Suicide 6 Could not be	28e. PLACE OF INJURY	— At home, farm, str			201. LOCATION (S		r or Rural Ro	ute Number,	-	
TED	4 Homicide determined	building, etc. (Speci	······································			City or Yown,	State)				
PLE	29a. CERTIFIER (Check only	AN: To the best of my knowl	edge, death occurred	at the time, data	and place, and due	to the cause(e) end	manner as sta	rted,			
COMPLET	one) 2 MEDICAL EXAMINER:	On the beele of examination	and/or investigation,	In my opinion, de	eath occured at the	time, data and place	e, end due to t	he cause(a)	end manner ea state	d.	
H	29b. SIGNATURE AND TITLE OF CERTIFIER	MD.			29c. LICENSE NU	MBER	29d. DAT	TE SIGNED (F	Month, Day, Year)		
5	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEA	THUTEM 27 Typo, P	Thing ton	Ave, a	clus Les Ho	un,	WZZ	1620		
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNA			/		====			_	
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		for STATE REGISTRAR		STATE OF MARY		/ DEPARTI				MENT	AL HYGIEN	E		
	1	1. DECEDENT'S NAME (First,	Middle, Last) ART F	INN LAND	M	an				MOM	E OF DEATH DO	"18 %	3.	TIME OF DEATH
Pj		4. SOCIAL SECURITY NUMB 227-22-0398	3	1 □ M 2 🖁 F 6		-	F UNDER 1 YEADNTHS DAY	-	UNDER 24 HRS.	(Mor	e of BIRTN (th, Day, Year) . 20, 1		BIRTHPLA Country) /irgi	ce (State or Foreign
. 2, 3 shou	стов	Meridian Mu	ırsing				Seve		Park	EATH		Anne		
ri. Pages 1	DIREC	10e. STATE Maryland	10b. COUNTY	rundel			rown or Lo		1					1. INSIDE CITY LIMITS? YES 2 X NO
an. ransit perm	FUNERAL	960 Indian	Landir	<u> </u>				101. ZIP	108			Unit		tates
MARYLAND 21215-0020 retained by the hospital or attending physician. 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should notified at once.	ВУ	1t. MARITAL STATUS 1 Never Married 2 3 Widowed 4 Divor		12. WAS DECEDENT EVER FORCES? 1 VES IF YES, GIVE WAR OR	2 X		If yea,	specify	DENT OF HISPAN y Cuban, Maxica 1 NO Specif	n, Puarto	N? (Specify Yea Rican, etc.)	or No — 14	Black, W Specify:	American Indian, hita, atc.
21215 ttal or atten 1 for use as	LETED	(Specify only Elementary/Secondary (0-	EDENT'S EDUC. highest grade of	ATION completed) College (1-4 or 5 +)	- 6	DECEDENT'S US Give kind of work fe. Do NOT use n	k done during stired.)	most of			b. KIND OF BUS		TRY	
MARYLAND retained by the hospit 5 should be detached notified at once.	COMPL	12 17. FATNER'S NAME (First, Mi	ddle, Last)		Bi	nder (I	rinti	-	MOTNER'S NA		Middle, Malden		ital	
RYL ed by th	BE C	Russell Bak		· · · · · ·						_	lexand			
MAR retained 5 should notified	5	190. INFORMANT'S NAME (7) Linda Board							Number or Rurel I				,	21108
BALTIMORE, I after death. Page 6 may be by the funeral director, page moval.		20e. METHOD OF DISPOSITION 1 Source 2 Cremetto 4 Donation 5 Other	ON n 3 □ Remo	val from State	b. PLACE	E AND DATE OF	DISPOSITION	(Neme o	of	OA	TE 20c. LO	CATION — CITY	or Town,	State
ALTIMOR death. Page 6 ma thereal director, p		21. SIGNATURE OF THE RAL		ENSEE	ort	Linco	22. NAME	AND A	ery 10/	CILITY				ryland
BALTIN er death. Pag the funeral dir val.		*/Llas	on 1	Dul		7	3401	Bla	ncoln F adensbu	rg E	Rd., Br	entwoo	d, M	D 20722
P.O. BOX 68760, h certificate be executed within — hours anding physician and completely filled in the Hygiene prior to burial, cremation, or reto or other traumatic event, the medi	CERTIFICATION	23. PART L Enter the disease or condition resulting in death) Sequentielly liet condition if any, leading to immediate. Enter UNDERLYII CAUSE (Disease or injuithet initiated eventa resulting in death) LAST	ai a ona, flate NG ry	DUE TO (OR AS	A CONSI	EOUENCE OF):					diec or respi	ratory arreal	,	Approximate interval Between Onset and Death
CORI ires that to signed by dealth and ws any is	MEDICAL C	PART II. Other aignifices	nt conditions	contributing to death	but not	recuiting in	the underly	ring ce	ouse given in	Part i.	24a. WAS AN PERFOR 1 TYES 2	MED?	CO OF	RE AUTOPSY FINDINGS ILABLE PRIOR TO MPLETION OF CAUSE DEATH?
> 0 =	N.	DID TOBACCO US	SE CONTR	IBUTE TO CAUSE (OF DE	ATH YES	NO NO		UNCERTAIN	N []			1[YES 2 NO
F # # # #	PHYSICIAN:	25. WAS CASE REFERRED TO EXAMINER?		HOSPITAL:			THEB!						-	
OF V PHYSICIA this certif with the	PHY	27. MANNER OF DEATH		28a. OATE OF INJURY (Month, Day, Year)		28b. TIME C	F 28c.	NJURY WORK?	AT Residence		SCRIBE NOW IF	JURY OCCUR	ED	
ON DING F	ED BY	2 Accident II	Pending Investigation Could not be letermined	26a. PLACE OF INJUR building, etc. (Sp	Y — At h	ome, farm, stra			2 NO	281. LO	CATION (Street a or Town, State)	nd Number or i	Rural Route	Number,
DI TAL OR TAL DIRE 72 hour	COMPLETED			IAN: To the best of my kno									Busa(s) an	d manner as stated
TO THE HOSPI TO THE FUNER TO THE FUNER TO THE HOSPI	TO BE CO	29b. SIGNAPORE AND TITLE	OF CERTIFIER	Alfer	do	Ÿ		-	c. LICENSE NUN		6		1	nth, Day, Year)
	Ĭ.	30. NAME AND ADDRESS OF SURYAP. 31. DATE FILED (Month, Day, Y	MU		ע	EMILT) (Type, Pri	CLA	N	YUY	A	106	GLEN	KUR	ME SIDE
		UUI 23 1995	Jako	Bushardian										<i>'</i>

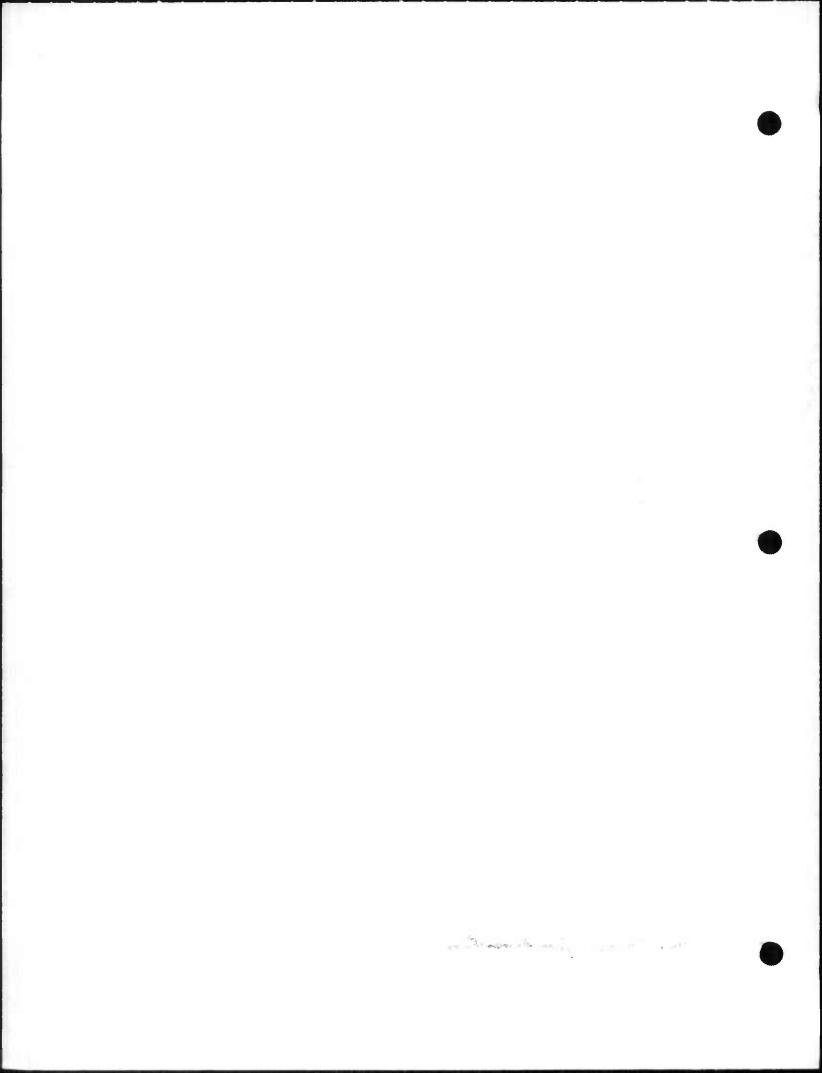
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DIVISION OF VITAL RECORDS, P.O. BOX 68760

TOTH HIGH ACTENDING PHYSICIAN: The law requires that the death certificate be executed within. Fhours after death, Page 6 may be retained by the hospital or attending	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	
THE HOSPITAL OR ATTENDING	THE FUNERAL DIRECTOR; After fled within 72 hours after death	PORTANT: If Item 28 is m:	
Ħ	23	3	1

FOR 1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CI	HILL	ICATE	OF [DEATH		REG. NO.			
52	1. DECEDENT'S NAME (First, Middle, Last) CHARLOTTE	L. LE	MKE					2. O	DATE OF DEATH ON DEATH OF DEAT	2, 19	95	3. TIME OF DEATH 6:26 P M
100	4. SOCIAL SECURITY NUMBER 474-09-4099	the second secon	AGE (In yrs. les	t birthday) YRS.	IF UNDER 1		IF UNDER 24 HR	. 7.	DATE OF BIRTH (Month, Day, Year) CLODER 5,		a Burryu	PLACE (Stere or Foreign
NG.	99. FACILITY NAME (If not institution, give s 6333 Naval Avenue					nown on	LOCATION OF	OEATH	1		NTY OF DE	
1 8	RESIDENCE OF DECEDENT											
DIRECTOR	MAryland Princ		10c. CIT La	nham	LOCATIO	N					10d. INSIDE CITY LIMITS? 1X YES 2 NO	
FUNERAL	100. STREET AND NUMBER 6333 Naval Avenue	2					20706			10g. CIT		HAT COUNTRY?
BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT E FORCES? 1 I IF YES, GIVE WAR	YES 2 X	MED IO	11	yes, speci	IDENT OF HIS Ify Cuban, Ma: NO Sp	dcan, P	ORIGIN? (Specify Year ruarto Rican, etc.)	or No-	14. RACE Black, Specifi Whi	- American Indian, White, etc.
0	15. DECEDENT'S EDU	CATION	16e DE	CEDENTIE	USUAL OC	UBATION						
COMPLETED	(Specify only highest grade Elementary/Secondary (0-12) 12		(Gi	Do NOT us	vork done du	ring most	of working		Self-En			
COM	17. FATHER'S NAME (First, Middle, Lest)					-	IS. MOTHER'S	NAME	(First, Middle, Maiden : Chulz	Surname)		
BE	Alfred Weston 198. INFORMANT'S NAME (Type/Print)		Lon	MAHINO	ADDRESS							
5	James A. Lemke		-					Lan	ham, MD	2070	16°00)	
	20a. METHOD OF DISPOSITION 1 Burlal 2 XI Cremation 3 Rem 4 Donation 5 Other (Specify)		20b. PLACE A cemetery, cre	metary or o	har place!			1			city or Tow	• • • •
	21. SIGNATURE OF FUNERAL BEHVIDE LICENSEE 22. NAME AND ADDRESS OF FACILITY Remon/Halle Funeral Home 9013 Annapollis Road, Lanham, MD 20706											
	23. PART /. Enter the diseases, or complications that coused the deeth. Do not enter the mode of duing such as cardiac or regulators arrest											
	INMEDIATE CAUSE (Final disease or condition	List only one cause	on asch line						ance		est,	Approximata Interval Between Onset and Death
	resulting in death)	DUE TO (OF	AS A CONSEC	DUENCE OF	7:	de	J	C.2	arres			2 Mons
TION	Sequentially list conditions, if sny, leading to immediate	DUE TO (OR	AS A CONSEC	UENCE OF	7):							
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disesse or Injury that Initiated events resulting in death) LAST	DUE TO (OR	AS A CONSEC	UENCE OF	ን:							
HH H	Total and the country Exist	d										
	PART II. Other algnificant condition	a contributing to de	eth but not re	esulting l	n the und	eriving c	ause given	in Par	t J. 24s, WAS AN	MITOPSY	24h	WERE AUTOPSY FINDINGS
DICAL	Dealuly HV	portense	in S	eir		2_			PERFOR	WED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE
MED		portense		0					1 TYES 2	NO		OF DEATH?
	DID TOBACCO USE CONTI	RIBUTE TO CAUS	E OF DEA	TH YE	S X N	0 🗆	UNCERTA	I NIA				
PHYSICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLAC	E OF DEAT	H (Check or	ly one)	1					
YSI	1 TYES 2 NO	1 Inpetient 2 EF	R/Outpatiant 3	□ DOA	4 Nursi	g Home	5 Resident	e 6 🗆	Other (Specify)			
ву Рн	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	26a. DATE OF INJ (Month, Day,)		26b. TIMI INJ	E OF URY M	Bc. INJUR WORK 1 YES	Y AT (? 5 2 NO	284	d. DESCRIBE HOW IN	JURY OC	CURED	
ETED	3 Suicide 6 Could not be determined	28e. PLACE OF IN building, atc.	IJURY — At hor (Specify)	ne, farm, s	treet, factor	y, office		281	f. LOCATION (Street at City or Town, State)	nd Number	or Rural Ro	oute Number,
COMPLE												
BE CO	295, SIGNATURE AND TITLE OF CERTIFIER											
욘	30. NAME AND ADDRESS OF PERSON WHI	COMPLETED CAUSE O	OF DEATH (ITEM	1 27) (Type,	Print)	- 4	//3) (4-	- (0/2	3/73
	F. Sotouche 31. DATE FILED (MONTH, DBY, YEAR)	h MD.	752	5 6	rec	we	ry Co	nt	er Dr- 0	bree	nhe	Month, Day, Year) 3/95 M-MD BUTTO
	OCT 241995 Jul	n d'endeart	artell									



1	FOR STATE REGISTR
	1. DECEDENT'S

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR	CERTIFIC	ALE OF	DEATH	REG	. NO.					
	1. DECEDENT'S NAME (First, Middle, Lest) JOHN RAYMOND LAWLESS			-	2. DATE OF DEA	DAY	3. TIME OF DEATH				
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In 577-18-1068 1 M 2 G F 82		F UNDER 1 YEAR DNTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRT (Month, Day, Y	н	995 6:15pm s. BIRTHPLACE (State or Foreign Country) Washington				
NC.	9s. FACILITY NAME (If not institution, give street and number) DOCTORS COMMUNITY HOSPI	TAL °		DR LOCATION OF DE	ATH	9c. COUN	TY OF DEATH				
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d.										
	Maryland Prince George's	Gre	enbelt			1 X					
FUNERAL	7010 Greenbelt Road 20770 USA										
B	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO If yes, specify Cuben, Maxican, Puerto Rican, etc.) 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No- If yes, specify Cuben, Maxican, Puerto Rican, etc.) 14. RACE — AI Black, Whit I YES NO Specify:										
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) Coffege (1-4 or 5+) Not Available	(Give kind of word life. Do NOT use n	k done during mo etired.)	ON st of working		ate Sec					
NOS	17. FATHER'S NAME (First, Middle, Last)	Haziree	nance	16. MOTHER'S NAM			201				
BE ((Not Available) Lawless				Availa						
2	Naomi T. Lawless			nd Number or Aural A							
	20a. METHOD OF DISPOSITION 20b. P	LACE AND DATE OF	DISPOSITION (No				∠U / 4 / ⊃ty or Town, State				
	4 Donation 5 Other (Specify)	ery, crematory or other hington	Nationa	1 Cemete	10/25/	95 Suit	tland, Md.				
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE		Franci	s Gasch	s Sons	Funeral	Home - 4739 Md. 20781				
ITION	Sequentially list conditions, if any, leading to immediate	CONSEQUENCE OF):	2	or dying, such	aa cardrag or	reapiratory arre	Approximate Interval Batwo Onset and De				
CERTIFICATION	CAUSE (Disease or injury that initiated events resulting in death) LAST	CONSEQUENCE OF):									
EDICAL	PART II. Other significant conditions contributing to death but	not resulting in t	the underlying	g cause given in I		AS AN AUTOPSY ERFORMED? ES 2	24b. WERE AUTOPSY FINDIN AWAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH?				
N.	DID TOBACCO USE CONTRIBUTE TO CAUSE OF	DEATH YES	□ NO 🗷	UNCERTAIN			1 WES 2 NO				
PHYSICIAN:	EXAMINER? HOSPITAL:	D. PLACE OF DEATH ((Check only one)								
HYS	t VES NO 11 Mpetient 2 ER/Outpet 27. MANNER OF DEATH 286. DATE OF INJURY		☐ Nursing Hom	e 5 ☐ Residence I		OW INJURY OCC	IDEO				
ВУ Р	1 Netural 5 Pending (Month, Day, Year) 2 Accident Investigation	INJUR	Y W0	RK? 'ES 2 NO	TOU. DESCRIBE		UNED				
TED	3 Suicide 8 Could not be datarmined 28e. PLACE OF INJURY building, stc. (Specify	- At home, farm, stre-	et, tectory, offic		281. LOCATION (S City or Town,		or Rural Route Number,				
COMPLET	29e. CERTIFIER (Check only one)										
	2 MEDICAL EXAMINER: On the bests of examination a	ind/or investigation, i	in my opinion, d								
TO BE	W (lung			D) 22	C (≥ / C	SIGNED (Month, Day, Year)				
	30. MAME AND ADDRESS OF PARTON WHO COMPLETED CAUSE OF DEAT	(ITEM 27) (Type, Pri		Ancis	ne	iArha	an -				
i	31. DATE FILED (Magnit, Day, 1997) 32/FIEGISTRAR'S SIGNAT	Ung H		=	· .		-				

THE HUSHIAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the flow star force. Page 6 may be retained by the hospital or attending physician.

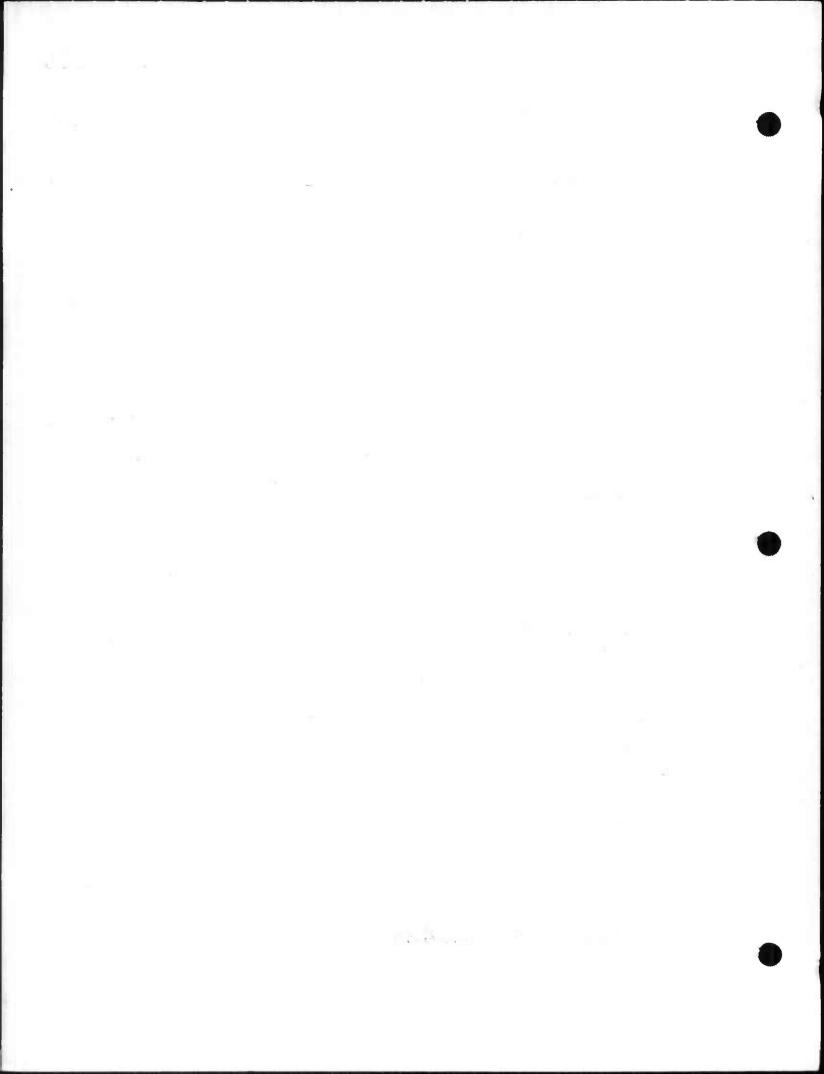
TO THE FUNETAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be flow within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

DHMH-18 Rev 1/89



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

											95	3	3398		
	Amended #5, 11/1/	95, SW, C	alvert C	o.							20		, 0 5 0		
	1 - FOR STATE REGISTRAR	STATE OF I	MARYLAND /	DEPAR	RTMEN	T OF	HEALTH F DEAT	AND I	MENT	AL HYGI					
	1. DECEDENT'S NAME (First, Middle, Let	*							2. DAT	E OF DEATH	DAY	VEAD	3. TIME OF DI	EATH	
	ALFRED	MELVIN	MOLES						OCI	17	, 19	95	10:45	рм	
	4. SOCIAL SECURITY NUMBER 224-32-4153	5. SEX	6. AGE (In yrs. le:		IF UNDI	DAYS	_	24 HRS.	7. DAT	E OF BIRTH)	Com			
	9a. FACILITY NAME (If not institution, giv		01	1 Lb. 17; 1714								VIRGIN	IA		
œ	Calvert County		'enter				ice Fr					TTO Y			
DIRECTOR	RESIDENCE OF DECEDENT	Airca			LIII	ice II	.eueı	LICK		Ca.	Calvert				
RE	10a. STATE 10b. COU			10c. CITY, TOWN OR LOCATION								10d. INSIDE C	TY		
		LVERT		PR	RINCI		EDERI				_		1 VES 2 NO		
RA	10e. STREET AND NUMBER	D				1	of. ZIP COD	3					EN OF WHAT COUNTRY?		
FUNERAL	85 HOSPITAL ROA	12 WAS DECEDED	IT EVER IN U.S. AF	MED	- 140	W 0 0	2067				Yes or No-	J. S.			
BY FL	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES7 1	YES 2 X	NO	13	If yes, a	specify Cuba	n, Maxica	n, Puarto	Ricen, atc.)	Yes or No-	Blo	CE — American Ir ick, White, atc.		
	15. DECEDENT'S E	DISCATION	10.00										WHITE	5	
ETE	(Specify only highest gra	ide completed)	(G	CEDENT'S live kind of Do NOT u	work done	e durina n	nost of working	ng	16	Sb. KIND OF	BUSINESS/IN	DUSTRY			
7	Elementary/Secondary (0-12) College (1-4 or 6+) 8TH MACHINE OPERATOR LUMBER														
COMPLETED	17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname)														
BE	CHRISTOPHER COL	UMBUS MOL	ES			_	LAV	ONIA	KE	ITH					
2	19a. INFORMANT'S NAME (Type/Print)							or Rural F			Town, State, Zi				
	WANDA H. NORCRO	SS		316 D							VA 24				
	1 Burial 2 □ Cremation 3 □ Re Donation 5 □ Other (Specify) □	moval from Stata	20b. PLACE : cemetery, cre CEDA	metory or o	of DISPO	MEMO	RIAL	PARK	10/	20,95	ROAN	OKE,	VA		
	21. SIGNATURE OF FUNERAL SERVICE	LICENSEE			22	. NAME	AND ADDRES	SS OF FAC	CILITY						
	· Bull I	Ten_				Rau	sch	Fun	era	l Ho	me, F	A,	Owings	, ME	
	23. PART I. Enter the diseases, p shock, or heart fally	r complications the e. List only one cau	t caused the de	eath. Do i	not ante	r the m	ode of dyl	ng, suci	n aa ca	rdiac or re	spiratory ar	rest,	Approxi	mata Between	
	IMMEDIATE CAUSE (Final disease or condition	Ca	rcinom	ofthe	a la	rumv							Onset a	nd Death	
	reaulting in death)	B	(OR AS A CONSE			Lylla	·								
_					, ,,										
IFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO	(OR AS A CONSE	DUENCE O	F):								-		
S	CAUSE (Disease or Injury	с													
	that initiated events resulting in death) LAST	DUE TO	(OR AS A CONSE	DUENCE O	F):										
CERT		d											1		
ÄL	PART II. Other algnificant conditi	one contributing to	death but not r	resulting	In the u	inderlyli	ng cause g	lven in	Part I.		AN AUTOPSY	24	MAILABLE PRIC		
MEDICAL									_	1 🗆 YES	2 📆 NO		OF DEATH?		
2	DID TOBACCO USE CON	ITPIRITE TO CA	LISE OF DEA	TU V	:c 🖂	NO [T UNC	ERTAIN	1 1071				1 TES 2] NO	
AN	25. WAS CASE REFERRED TO MEDICAL	INDOIL TO CA		E OF DEA				EKIAII	M IAJ						
Sic	1 YES 2 NO	HOSPITAL: 1 Inpatient 2	ER/Outpatient 3	□ DOA	OTHE	B+ Irsing Ho	me 5 🗆 Ra	sidence	6 🗆 Oth	er (Specify)					
BY PHYSICIAN:	27. MANNER OF DEATH 1 Netural 5 Pending	28a. DATE OF (Month, D		28b, TIM		28c. IN	JURY AT ORK?		_		W INJURY OC	CURED			
2 Accident Investigation M 1 YES 2 NO															

28a. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify)

death occured at the time, data and place, and due to the cause(a) and menner as stated.

20678

28t, LOCATION (Street and Number or Rural Route Number, City or Town, State)

29h. SIGNATURE AND TITLE OF CERTIFIE 29c. LICENSE NUMBER

D03077

29d. DATE SIGNED (Month, Day, Year) ▶ 10/18/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF PERSON STORES PRINCIPLE STORES PRINCIPLE STORES AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF PERSON STORES AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF PERSON STORES AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF PERSON STORES AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF PERSON STORES AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF PERSON STORES AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF PERSON STORES AND ADDRESS AND ADDRESS AND ADDRESS AND ADDRESS AND ADDRESS AND ADDRESS AND ADDRESS AND ADDRESS AND ADDRESS AND ADDRESS AND ADDRESS AND ADDRESS AND ADDRESS AND ADDRESS AND ADDRESS AND ADDRESS AND ADDRESS AND ADDRESS AND ADDRESS Issam Damalouji

1 X CERTIFYING PHYSICIAN: To the 2 MEDICAL EXAMINER: 0

2 Accident 3 Suicide

4 Homicide

29a. CERTIFIER (Check only one)

COMPLETED

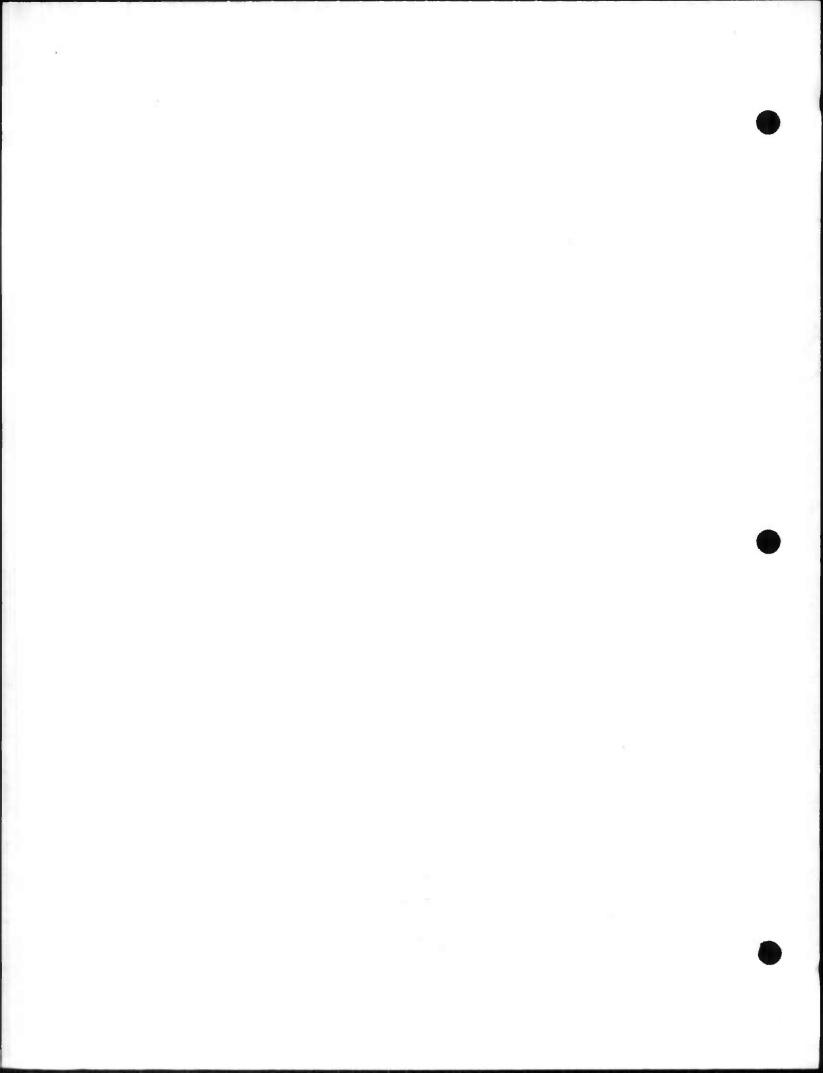
BE

2

Prince Frederick, MD

31. DATE FILED (Month, Day, Year)

OCT 26 32. REGISTRAR'S SIGNATURE
Julia Davidson Randall

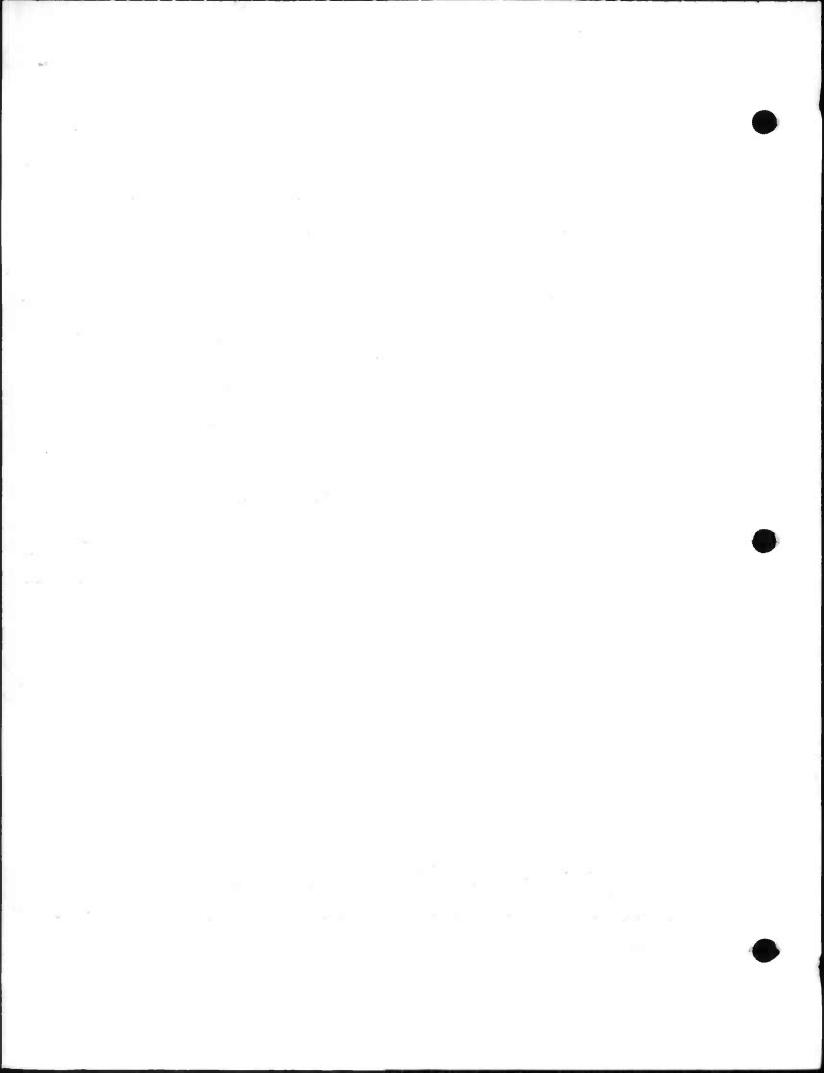


BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 687604

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with an order of the death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	FOR 1 - STATE REGISTRAR	STATE OF MARYLA	ND / DEPARTM CERTIFIC				YGIENE EG. NO.		
	1. DECEDENT'S NAME (First, Middle, Lest)					2. DATE OF I		YEAR	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER		IE MESSNE			OCTOB	ER 28,	1995	6:10 p. M
	215-09-6985	1 M 2 X F		UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF B (Month, Date DEC . 22	(Year)	Cou	THPLACE (State or Foreign ntry) NEYTOWN, MD.
OR	98. FACILITY NAME (If not institution, give str ST. CATHERINE'S NU RESIDENCE OF DECEDENT			EMMIT:	R LOCATION OF DI	EATH		REDER	
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		7	OWN OR LOCATI				Neben.	10d. INSIDE CITY
	MARYLAND FREDE	ERICK	THURM	ONT, MI	D.				LIMITS?
FUNERAL	15904 ST. ANTHONY			101.	21788		109	U. S	what country?
B⊀	11. MARITAL STATUS 1 Never Married 2 Married 3 💢 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 ☐ YES IF YES, GIVE WAR OR DA	3 NO	13. WAS DECE If yes, spe 1 — YES	city Cuban, Maxica	in, Puerlo Rican	pecify Yea or N , etc.)	Ble	CE — American Indian, ick, White, atc.
COMPLETED	15. DECEDENT'S EDUC. (Specify only highest grade of Elementary/Secondary (0-12)	ATION completed) College (1-4 or 5+)	18a. DECEDENT'S USU (Give kind of work life. Do NOT use re WAITRESS	done during mos tired.)	N t of working	MT.	ST. M	ARY'S	COLLEGE
NO.	17. FATHER'S NAME (First, Middle, Lest)		WAT THE DO	T	18. MOTHER'S NA				
BE C	WILLIAM BAS	SSET SHOEMAK					FORMA		
5	190. INFORMANT'S NAME (Typo/Print) DONALD SHOEMAKER				Mumber or Rural			ite, Zip Code)	
	20a. METHOD OF DISPOSITION	206.	PLACE AND DATE OF D	ISPOSITION (Nan	TANEYTOW ne of	OATE		ON — City or	Town, Stata
	1 🂢 Burial 2 🗆 Cremation 3 🗆 Ramor 4 🗆 Donation 6 🗆 Other (Specify)	EL	IAS LUTHE	RAN	10/31/9	5	EMMIT	SBURG.	MD, 21727
	21. SIGNATURE OF FUNERAL SERVICE LICENSES M. Skiles 22. NAME AND ADDRESS OF FACILITY SKILES FUNERAL HOME 210 W. MAIN ST., EMMITSBURG, MD. 21727								
CERTIFICATION	23. PART . Enter the diseases, or conshock, or heart failure. L iMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentisity list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	OUE TO (OR AS A COUR TO (OR A COUR TO (OR A COUR TO (OR A COUR TO (OR A COUR TO (OR A COUR TO (OR A COUR TO (OR A COUR TO (OR A COUR TO (OR A	ch lina. Plape consequence of: Pulse consequence of:						Approximate Interval Batween Onset and Death 3 days Years
CERTIF	that initiated events resulting in death) LAST	Delansered version	CONSEQUENCE OF)						
MEDICAL	PART II. Other significant conditions	contributing to death bu	t not resulting in ti	na underlying	cause given in	1	WAS AN AUTO PERFORMED YES 2 X N	?	Ib. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
	DID TOBACCO USE CONTR			X NO □	UNCERTAIL	N 🗆			
Sic.		HOSPITAL: 1 Inpatient 2 ER/Outper		THER:					
PHYSICIAN:	27. MANNER OF OEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF	28c. INJU		8 U Other (Spi 28d. OESCRIB	- 77	Y OCCUREO	
ВУ	1 Natural 5 Pending 2 Accident Investigation	-		M 1 Y					
	3 Suicide 8 Could not be 4 Homicide datarmined	28a. PLACE OF INJURY - building, atc. (Specif	— At home, farm, stras	t, factory, offica		281. LOCATION	(Street and Novn, State)	umber or Rura	l Route Number,
COMPLETED		IAN: To the best of my knowle : On the bests of exemination							(s) and manner as stated.
BE C	290. SIGNATORE AND TITLE ON GENOTIER	he m	2		29c. LICENSE NUN				O (Month, Dgy, Year)
2	50. NAME AND ADDRESS OF PERSON WHO	OMPLETED CAUSE OF DEAT	TH (ITEM 27) (Type, Prin	()	V 228	5/9		10/	30/95
	BRAD J. Co	32. REGISTRAR'S SIGNAL	D. 52	WATE	est, 7	HURM	ONT.	MD.	21788
	OCT 3 0 1995	Davely			,				



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attent	THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: Il Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
6	2	De 1	E

SZ 7. J.

31. OATE FILED (MONTH, Day, Year)

OCT 30

DRIVE

1995

1 - REGISTRAR	SIMIE UF MIANT		CATE OF		MENTAL HYGIEN REG. NO			
1. DECEDENT'S HAME (First, Middle, Last) Olive Irene	Mount				October 2		year 3. TIME OF DEATH 95 8:25 P	
		(In yrs. lest birthdey) OO YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	March 9,1	895	s. BIRTHPLACE (Store or Foreign Country) Maryland	
99. FACILITY HAME (II not institution, give stree Frederick Mem		ital		or Location of D ederick	EATH		rederick	
10a. STATE 10b. COUNTY	lerick	10c. CITY	, TOWN OR LOCA	ederick		V.	10d. INSIDE CITY LIMITS? 1 X YES 2 NO	
10e. STREET AHD HUMBER 990 Waterford D 11. MARITAL STATUS 11 Naver Married 2 Married	r.		10	1. ZIP CODE 21702			ted States	
11. MARITAL STATUS 1 Never Merried 2 Married 3 Widowed 4 Divorced	2. WAS DECEDENT EVER FORCES? 1 YES IF YES, GIVE WAR OR	S 2 KHO	If yes, sp		NIC ORIOIN? (Specify Year, Puerto Ricen, etc.) y:	a or No—	14. RACE — American Indian, Black, White, stc. Specify White	
(Specify only highest grade cou	15. DECEDENT'S EDUCATIOH (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2 16a. DECEDENT'S USUAL OCCUPATIOH (Give kind of work done during most of working life. Do NOT use retired.) School Teacher							
17. FATHER'S HAME (First, Middle, Last) Albert N	. Mount				tha C. Fis			
190. IHFORMAHT'S HAME (Type/Print) Arlene Runkle	S				Airy, Md.			
20e. METHOD OF DISPOSITION 130 Burlel 2 Cremation 3 Removie 4 Donetion 5 Other (Specify) 21. SIONATURE OF FUHERAL SERVICE LICEH	al from State	ob. PLACE AND DATE Commetery, crematory or of Pine Gro	ve Ceme	tery 10/	31/95 M	t. Aiz	ry, Md. 21771	
23. PART I. Enter the diseasea, or cor shock, or heart feliure. List iMMEDIATE CAUSE (Finel disease or condition resulting in death)	ARRHY	eech line.	not enter the me		Rd., Damas		Approximate interval Batwe Onset and Dec	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that infiliated events resulting in death) LAST	CONGES DUE TO (OR AS		HEART	FAIL	ukē		HOURS	
PART II. Other algorificant conditions FRACTURE	RIGHT	HIP-7	057 Su	REEKY	1 TYES	PRMEO?	24b. WERE AUTOPSY FINDIN AWAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 NO	
	BUTE TO CAUSE HOSPITAL: X Inpetient 2 ER/O	26. PLACE OF DEAT	OTHER:)	8 ☐ Other (Specify)			
27. MANNER OF DEATH	27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 1 Hetural 5 Pending 28e. DATE OF INJURY (Month, Day, Year) 1 Yes 2 No 6666							
	280. PLACE OF INJU			СФ	281. LOCATION (Street) City or Town, State	end Number	or Rural Route Number, PEDE	
2 X Accident Investigation	SUNR	ISE N.H			1 / 2 20 1		ントリント	
2 M Accident Investigation 3 Suicide 6 Could not be determined 29e. CERTIFIER 1 CERTIFYING PHYSICI.	SUNR. AN: To the best of my kn	owledge, death occurr	ed at the time, dat		e to the cause(s) end m	enner aa atate		

FREGERIC

32. RECISTRAN'S SIGNATURE
REVOLUNT REVOLUTION REVOLUTION

21702

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31. DATE FILED (Month, Day, Year)

OCT 3 0 1995

			1 - STATE REGISTRAR		STATE OF I	MARYL	AND /	DEPAR	TMENT	OF OF	HEALTH	AND I	MENTA	L HYGIE					
			1. DECEDENT'S NAME (First	, Middle, Lest)										OF DEATH			3. TIME OF DEATH		
O			Kenne	eth J	ames Mo	rris							MON	CT	27	95	2154		
2		4. SOCIAL SECURITY NUME	JER	5. SEX	6. AGE (In yrs. las	t birthday)	IF UNDER		_	R 24 HRS.	7. DATE	OF BIRTH	17	8. BIRT	IPLACE (State or Foreign			
		219-64-01	09	1 X M 2 🗆 F	4:	1	YRS.	MONTHS	DAYS	HOURS	MIN.		28,	1954	Count	ryland			
	3 should		9a. FACILITY NAME (If not in	stitution, give	street and number)					Y, TOWN OR LOCATION OF DEATH					-	INTY OF E			
7.		СТОВ	500 West Ma		Hagerstown							Washington							
	permit. Pages 1.	ш	10a. STATE	10b. COUNT		10c. CITY, TOWN OR LOCATION									10d. INSIDE CITY				
	4:	DIR	Maryland	Mo	ntgomery			C	larks	sbuı	rg			NO YES 2 NO					
	E Deci	ERAL	10e. STREET AND NUMBER								or. ZIP COD	E			10g. CIT	IZEN OF	WHAT COUNTRY?		
5	burial-transit	剪	22813 Clar	kbroo	ke Drive			20871								U.S.	Α.		
20	irial-ti	FUN	11. MARITAL STATUS 1 Never Married 2	Mandad	12. WAS DECEDEN FORCES? 1			U.S. ARMED 13. WAS DECENDENT OF HISPAN							fes or No —	14, RAC	E — American Indian, k, White, atc.		
5-0020	g a a		3 Widowed 4 Divo								If yes, specify Cuben, Mexican, Puerto Rican, std.) 1 ☐ YES 2 X NO Specify:					Specify: White			
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A S	retained by 5 should be notified at	OM	17. FATHER'S NAME (First, M	iddle, Last)							16, MOT	HER'S NA	ME (First.	Middle, Maide	on Sumame)				
		- 1	Charles I	Mo.	rric	rie													
AR being		0	19m. INFORMANT'S NAME (7			191	MAILING	ADDRESS	(Street	and Number	r or Rumil F	Toute Nun	Nicho	US own, State, Zi	o Code) 🤈	0071			
		۲	19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Joan H. Morris 22813 Clarkbrooke Drive, Clarksburg, Ma										_						
H A	page st pe	i	20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of										DATE 20c. LOCATION — City or Town, State						
0 9	must		**Montgomery Crematorium 10/29 Bethesda, Maryland										aryland						
ALTIMOR	the funeral director, yal.		21. BIGHATURE OF FUNETAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY																
AL	fune Exam	- 1	Olin L. Molesworth, P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 2087																
BALTIMORE,	removal		23. PART I. Enter the di	seases, or				nth. Do n	1 26	1401	Rid	ge R	oad.	Dama diec er ree	SCUS.	Mar	vland 20872 Approximate		
nours	filled in by the		snow, or n	eart fallure.	List only one cau	se on e	ch line.				out of uy	mg, add		OIEC OI IGE	piratory at	rout,	Interval Between		
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36	sician and c rior to buris traumatic	CATION	Sequentially liet conditi		DUE TO	(OR AS A	CONSEC	UENCE OF	7):										
BOX		8	cause. Enter UNDERLY! CAUSE (Disease or Inju		SEQUENCE OF):														
O. B.	giene other	RTIFI	that initiated events	CONSEC															
٩. (RDS, Port the death by the attented on Mental 1 injury, o	H	resulting in death) LAS	' (d														
S.		- 11	PART II. Other significa	nt condition	ne contributing to	deeth be	ut not re	euiting I	n the un	derivin	o causa (niven in	Part I	24n WAS A	IN AUTOPSY	246	. WERE AUTOPSY FINDINGS		
		2	PART II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY PERFORMED?											-	AVAILABLE PRIOR TO COMPLETION OF CAUSE				
L RECOR law requires that is been signed by lept. of Health an 23 shows any AN: MEDICA	입	1 YES 2 NO										OF DEATH?							
The light	e been signed to be beet of Health a m 23 shows any	Σ	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO WUNCERTAIN											1 YES 2 NO					
AL ME	20 _	AN:	25. WAS CASE REFERRED TO		KIBOTE TO CA							EKIAII	ч Ц						
-	State	SICI	EXAMINER? HOSPITAL: OTHER:																
L S	the the	≟ ∥	27. MANNER OF DEATH		28a. DATE OF		1	28b. TIM	-			esidence			IN HIRY OC	CUREO			
O F	fter this cath with marked	۵]	1 Netural 5 Pending (Month, Day, Year) INJURY WORK?							ORK?	28d. DESCRIBE HOW INJURY OCCURED								
ONIG	4 D 00	D BY	2 Suitable	— At hor	7.7					281. LOCATION (Street and Number or Rural Route Number,									
/ISION ATTENDING	2 a 2	8	3 Suicide 8 Could not be determined 28e. PLACE OF INJURY — At home, farm, street, factory, offi building, atc. (Specify) Petrostics Centor							tail	City or Town, State)								
DIVISION OR ATTENDING	DIRECTOR: hours after Item 28 I	۳	29a. CERTIFIER	FYING PHYS	ICIAN: To the heet of	rm knowl							700		Md	-	RKUMY		
HOSPITAL	42 =	OMPLI			ICIAN: To the best of a) and menner as stated.		
HOSE	FUNER within		296. SIGNATURE AND TITLE			7.7					,			- arm proces, i					
뿓	불물	B	STATE AND THE	70	110	1					29c. LICE	ENSE NUM		,	29d, DAT	E SIGNED	(Month, Day, Year)		
2	2 ≥ ≤	2	30. NAME AND ADDRESS OF	PERSON WI	O COMPLETED CALL	SE OF DE	TH ATEN	27) /5 ===	Onine)		/	///	26	6	10	ct	278		

32. REASTRANG SIGNATURE
Successor Reveall

TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: 9

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 sh within 72 hours after death with the State Debt, of Health and Mental Hydiene prior to burial, cremation or removal.	STANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
IR ATTENDING PHYSICIAN: The I	IRECTOR: After this certificate har units after death with the State De	em 28 Is marked, or item 2
HOSPITAL	FUNERAL within 72 h	TANT: If I

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DIRECTOR

FUNERAL

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COMPLETED

CERTIFICATION

MEDICAL

PHYSICIAN:

ВУ

COMPLETED

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29b. SIGNATURE AND TITLE OF CERTIFIER

31. DATE FILED (Month Day

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Marle

Rd

'95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

MI

Chestertown, MD

32. REGISTRARIE SIGNATURE
Julia Davidson-Randelle

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 1995 Barbara Morrison W. October 1:33 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign Country) 7. DATE OF BIRTH September 7, DAYS HOURS 1 🗌 M 2 💢 F MIN. 1916 Rhode Island 016-12-6425 79 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATN The Kent and Queen Anne's Hospital, Ind. Kent Chestertown RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Kent Chestertown 1 X YES 2 | NO 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? Cottage 487 Heron Point 21620 United States 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 XNO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian, Black, White, etc. 1 Never Married 2XMarried If yes, specify Cuban, Maxican, Puarlo Rice

1 YES 2 NO Specify: IF YES, GIVE WAR OR DATES 3 Widowed 4 Divorced White 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Elementary/Secondary (0-12) College (1-4 or 5+) 12 4 Homemaker Domestic / Own Home 17. FATHER'S NAME (First, Middle, Last) 16. MOTNER'S NAME (First, Middle, Maiden Surname) Ralph Strafford Wentworth Gladys Kaull 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Charles Henry Morrison Cottage 487 - Heron Point, Chestertown, Maryland 21620 20a. METHOD OF DISPOSITION
1 Burlal 2 A Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, Stata Capitol Crematory - October 17, 1995 4 Donation 6 Other (Specify) Dover, Delaware 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY
Fellows - Wells Funeral Home William L. King Jr. 413 West High Street, Chestertown, Maryland 23. PART I. Enter the diseases, or complications that claused the death. Do not enter the mode of dying, such se cardiac or respiratory arrest, shock, or heart failure. List only one cases on each life. Approximate Interval Between IMMEDIATE CAUSE (Finel disease or condition resulting in death) a. CARGON DIDXIDE

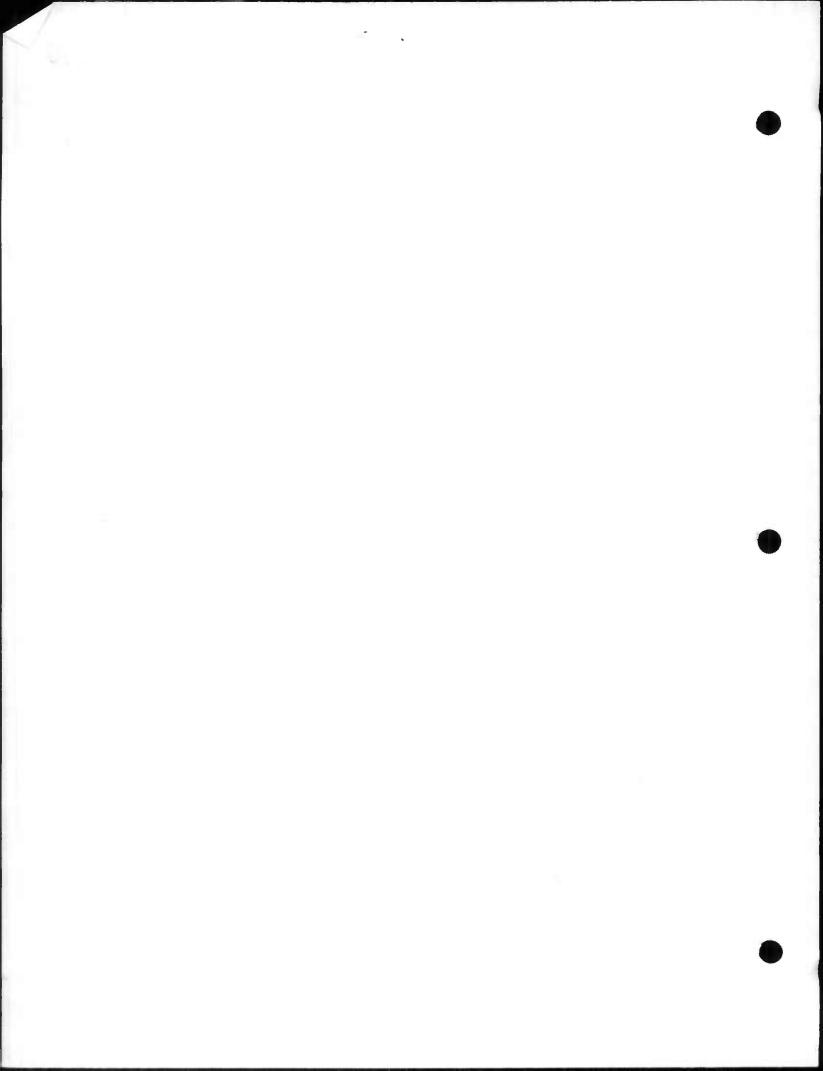
DUE TO (OR AS A CONSEQUENCE OF): RETENTION horus EMPHYSEMA Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in deeth) LAST PART II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PULMONALE 1 TES 2 NO 1 TES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL:
1 | Inpetient 2 | ER/Outpetient 3 | DOA OTHER: 1 YES 2 NO 4 Nursing Home 5 Realdence 6 Other (Specify) 27. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) Natural 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE NOW INJURY OCCURED 5 Pending Investigation 1 YES 2 NO Accident 28e. PLACE OF INJURY — At home, farm, street, factory, offica building, etc. (Soecify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be 4 Homicide 29a. CERTIFIER 1 CERTIFYING PNYSICIAN: To the best of my knowledge, desth occurred at the time, data and place, and due to the cause(a) and menner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated.

29c. LICENSE NUMBER

D41587

29d. DATE SIGNED (Month, Day, Year)

Helen A. Noble



BALTIMORE, MARYLAND 21215-0020	the manufactual within thouse other death. Done & grow he certained has the bosoited or settlement of miles
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BALTIM	offer death Dans
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BOX 68760	monday with
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TO THE HOSPITAL OR ATENDING PHYSICIAN: The law requires that the death certificate be executed within the hours after death. Page 6 may be retained by the burief-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to buriaf, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR STATE REGISTRAR	STATE OF N							-				
1. DECEDENT'S NAME (First, Middle, Last) Gerley	Junious	, M	Melvi	n J	r		2. DATE OF DEATH	M 14			A	
4. SOCIAL SECURITY NUMBER	5. SEX	1171:111:00			-	MIN.	7. DATE OF BIRTH (Month, Day, Year)	Country)	n		
9e. FACILITY NAME (If not institution, give str	reet end number)	62					ATN					
RESIDENCE OF DECEDENT 10a. STATE MD				TOWN OR LOC	ATION			10d. INSIDE CITY	=			
10s. STREET AND NUMBER			1 '			CIU	· <u>Y</u>	1 YES 2 10g. CITIZEN OF WHAT COUNTRY?				
11. MARITAL STATUS 1 Never Married 2 Americal 3 Widowed 4 Divorced	If yes, s	specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc.										
(Specify only highest grade of Elementary/Secondary (0-12)	rk done during r retired.)	nost of working	ost of working									
	Gerley				Sr.		Catherin	ne Ca				
	11		14716	6 Hal:	lfax	Rd.	Carson	Va.	2383			
1 Buriel 2 Cremation 3 Remo	1			^{∄plac} Ceme	etery		ct 20 95	Pet	ersk	ourg Va.	_	
1xogin	1/14	usor	n	P	DB 18	8 M	lckenney	Va.2	23872	_		
23. Part I. Enter the diseases, or conshock, or heart failure. Limited in the constant of the	let only one cau	yperte	nsive							Approximata interval Betwood Onset and Decular Di	eeth	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	OUE TO											
		death but not r	resulting in	the underlyl	ng ceuse gi	ven in i	PERFO	RMED?		AMAILABLE PRIOR TO COMPLETION OF CAUS		
25. WAS CASE REFERRED TO MEDICAL	IBUTE TO CA					RTAIN		ecti	on	1 YES 2 NO		
1X NES 2 NO 1 Inpetient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 The idence 8 Other (Specify)												
X Netural 5 Pending (Month, Day, Year) INJURY W 1						NO	281. LOCATION (Street and Number or Rural Route Number, City or Town, State)				4	
4 Nomicide determined	4					- 1						
4 Nomicide determined 29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSIC (Check only one) 2 Mécoical Examiner	DAN: To the best of a	my knowledge, de	eath occurred	at the time, da	e end place, e	and due t	to the cause(e) end me	nner ee atal	ed.		\dashv	
	1. DECEDENT'S NAME (First, Middle, Lest) Gerley 4. SOCIAL SECURITY NUMBER 212-28-4440 99. FACILITY NAME (If not institution, give st 1424 Prestman RESIDENCE OF DECEDENT 100. STATE 100. COUNTY MD 100. STREET AND NUMBER 1424 Prestman 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced 12. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12) 17. FATHER'S NAME (First, Middle, Lest) 190. INFORMANT'S NAME (Type/Print) Edna She 200. METHOD OF DISPOSITION 18. Burlel 2 Cremention 3 Remoded Development (Note of Specify) 21. SIGNATURE OF DIMERAL SERVICE US 23. PART F. Enter the diseases, or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significent conditions Diabete DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL EXAMINER? TX Natural 5 Pending Investigation 27. MANNER OF OEATN XM Natural 5 Pending Investigation 28. Natural 5 Pending Investigation 29. Accident Investigation	1. DECEDENT'S NAME (First, Middle, Lest) Gerley Junious 4. SOCIAL SECURITY NUMBER 212-28-4440 9. FACILITY NAME (If not institution, give street end number) 1424 Prestman St RESIDENCE OF DECEDENT 10a. STATE MD 10b. COUNTY MD 10c. STREET AND NUMBER 11. MARITAL STATUS 10b. COUNTY MD 10c. STREET AND NUMBER 11. MARITAL STATUS 10b. COUNTY MD 11. MARITAL STATUS 10b. COUNTY MD 11. MARITAL STATUS 11. MARITAL STATUS 12. WAS DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 + 10) 17. FATHER'S NAME (First, Middle, Lest) Gerley 19c. INFORMANT'S NAME (Type/Print) Edna Shell 20a, METHOD OF DISPOSITION 1 (Specify only highest grade completed) 21. SIGNATURE OF EUNERAL SERVICE LICENSES 21. SIGNATURE OF EUNERAL SERVICE LICENSES 22. MARY Leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DIA DETES DID TOBACCO USE CONTRIBUTE TO CAI 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1XYES 2 NO 27. MANNER OF OEATN XM SALVER STATUS SI Pending Investigation investigation 28e. PLACE OI 27. MANNER OF OEATN XM Natural SI Pending Investigation 28e. PLACE OI 27. MANNER OF OEATN XM Natural SI Pending Investigation 28e. PLACE OI 27. MANNER OF OEATN XM Natural SI Pending Investigation 28e. PLACE OI 28	STATE REGISTRAR 1. DECEDENT'S NAME (First, Middle, Lest) Gerley Junious A 4. SOCIAL SECURITY NUMBER 212-28-4440 S. SEX 6. AGE (In yrs. In 212-28-4440 S. SEX 212-28-28-4440 S. SEX 212-28-28-4440 S. SEX 212-28-28-4440 S. SEX 212-28-28-4440 S. SEX 212-28-28-4440 S. SEX 212-28-28-28-28-28-28-28-28-28-28-28-28-28	STATE REGISTRAR 1. DECEDENT'S NAME (First, Middle, Last) Gerley Junious Melvii 4. SOCIAL SECURITY NUMBER 2. S. SEX S. AGE (In yrx. last birthday) 2. 12 - 28 - 4440 9. PACHITY NAME (In to Institution, give street and number) 1.424 Prestman St NESIDENCE OF DECEDENT 109. STATE 109. S	1. DECEDENT'S NAME (First, Middin, Last) Gerley Junious Melvin Junious Junious Junious Junious Junious Junious Junious Junious Junious Julio	1. DECEDENT'S HAME (First, Middle, Last) STATE REGISTRAR SECURITY NUMBER 2.12-28-4440 1. M 2 F 62 YRS. 4. AGE (in yx. lisst birthody) MOLYIN 3. SECURITY NUMBER 2.12-28-4440 3. SEX 2.12-28-4440 3. SEX 2.12-28-4440 3. SEX 3. AGE (in yx. lisst birthody) MOLYIN 3. SECURITY NUMBER 2.12-28-4440 3. SEX 3. AGE (in yx. lisst birthody) MOLYIN 3. SECURITY NUMBER 3. SEX 3. AGE (in yx. lisst birthody) MOLYIN 3. SECURITY NUMBER 3. SEX 3. AGE (in yx. lisst birthody) MOLYIN 3. SECURITY NUMBER 3. SEX 4. AGE (in yx. lisst birthody) MOLYIN 3. SECURITY NUMBER 3. AGE (in yx. lisst birthody) MOLYIN 3. SECURITY NUMBER 4. COUNTY 4. SOCIAL SECURITY 4. SECURITY NUMBER 5. SEX 4. AGE (in yx. lisst birthody) MOLYIN 5. SECTY, TOWN OR LOCATION Baltimore 5. SECTY, TOWN OR LOCATION Baltimore 10. ZIP CODE 10. ZIP CODE 11. WAS DECEDENT OR 11. Yes specify Obera 1	1. SECRETIFICATE OF DEATH 1. DECCENT'S MAME (First, Mickels, Last) Gerley Junious Melvin Jr 4. SOCIAL SECURITY NUMBER 212-28-4440 1	1. DECEDENTS HAME (First, Models, Last) CERTIFICATE OF DEATH REGISTRAN CERTIFICATE OF DEATH REG. N. DECEDENTS HAME (First, Models, Last) CERTIFICATE OF DEATH REG. N. DECEDENTS HAME (First, Models, Last) S. SEX 1. DECEDENTS HAME (First, Models, Last) S. SEX 1. DECEDENTS HAME (First, Models, Des Indicated and Auctions) S. SEX 1. DECEDENTS HAME (First, Models, Des Indicated and Auctions) S. SEX 1. DECEDENTS HAME (First, Models, Des Indicated and Auctions) S. SEX 1. DECEDENTS HAME (First, Models, Des Indicated and Auctions) S. SEX 1. DECEDENTS HAME (First, Models, Des Indicated and Auctions) S. SEX 1. DECEDENTS HAME (First, Models, Last) S. SEX 1. DECEDENTS HAME (First, Models, Last) S. DECEDENTS HAME (First, Models, Las	STATE STAT	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG. NO. 1. DECEDITY NAME (First, Modes, Last) GETLEY JUNIOUS Melvin Jr 2. DATE OF BRATH REG. NO. 2. DATE OF BRATH REG. NO. 2. DATE OF BRATH REG. NO. 3. DATE OF BRATH REG. NO. 4. SOCIAL SECURITY NAMES 4. SECK 2.12 - 28 - 4.449 1. W 2 F	STREET IN ALL PRESIDENCE OF DEATH RECORDITS HAME (Figs. Modes, Late) Services Services Melvin Jr Services Melvin Jr Services Melvin Jr Services Melvin Jr Services Melvin Melvin Jr Services Melvin Melvin Melvin Jr Services Melvin Melvin Jr Services Melvin Melvin Melvin Jr Services Melvin Melv	

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
David R. Fowler III Penn Street, Baltimore, Maryland 21201

2 hears war signature

31. DATE FILED (Month, Day, Ybar) OCT 23 1995

DIVISION OF VITAL RECORDS, P.O.

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HOSPITAL DR. PUNERAL DIRE WITHIN 72 hours	HISPINL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	FUMERIAL DIRECTOR; After t	ed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burkal, cremation, or removal.	TIME II item 28 is marked or item 23 shows any injury or other traumatic event the medical examiner must be notified as eace
TO THE HOS TO THE FUN THE MIND WITH	TO THE HOS	TO THE FUR	The filed with	MAPORTAN

	FOR FilmG, 729,	item #6	11/27	/95, C	w, per	T.h.	AND ME	NITAL LIVOITAL	-		
	1 - STATE REGISTRAR	SIMIE UF	MART LAND	CERTIF	ICATE C	OF DEAT	AND ME	REG. NO.	E		
	1. DECEDENT'S NAME (First, Middle, Last)						2.	DATE OF DEATH DA	IA.	YEAR	3. TIME OF DEATH
	LERON MARI				,			CTOBER 24	1. 19	95	9.32 P M
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. 56	lest birthday) YRS.	IF UNDER 1 YE	-	24 HRS. 7. MIN.	DATE OF BIRTN (Month, Day, Year)		Country)	
	379-40-2100 9a. FACILITY NAME (If not institution, give		60	Tna.	as CITY TO	WN OR LOCATE		une 6,193		Vorti	Carolina
E E								1			
5	11007 Winsford AV					r Marl	boro		Pri	ice c	Beorge's
DIRECTOR	MD Princ	v ce George	La		Y, TOWN OR L						10d. INSIDE CITY LIMITS?
	10a. STREET AND NUMBER	e George	S	1 օնե	er Mar	101, ZIP CODE	E		10a CITIZ		1 YES 2 NO
FUNERAL	11007 Winsford Av	re.				207			log. orna		5.A.
S	11. MARITAL STATUS	12. WAS DECEDED	T EVER IN U.S.	ARMED	13. WAS	DECENDENT C	F NISPANIC	ORIGIN? (Specify Yes	or No-	14. RACE -	- American Indian, White, atc.
ВУ	1 Never Married 2 Married 3 Widowed 4 Divorced		MAR OR DATES	<u>C</u> NO		YES 2 MO		varto Rican, atc.)		Specify.	
	15. DECEDENT'S EDU	CATION	164.	DECEDENT'S	USUAL OCCUI	PATION		18b. KIND OF BUS	INESS/INDI		ack
ETED.	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5		(Give kind of life. Do NOT u	work done during se retired.)	g most of working	ng		JII (12.00/III D	John	
COMPL		4yrs		Teach	er			Governm	nent		
8	17. FATNER'S NAME (First, Middle, Last)			_		18. MOTI	NER'S NAME	(First, Middle, Maiden	Surname)		
H	Hiawatha Berry 19s. INFORMANT'S NAME (Type/Print)							Moore			
2								Number, City or Town			270
	George Meredith		20b. PLAC		WINST OF DISPOSITION		e. Up	per Marlh	CATION — C		
	1 Buriel 2 Cremetion 3 Fem 4 Donation 8 Other (Specify)	novel from State	cemetery.	crematory or o			1	oct 30	tfio		
	21. SIGNATURE OF FUNERAL SERVICE LI				22. NAM	E AND ADDRES	SS OF FACILI	TY		LO,N.	
	> Humberly	- Dusc	COC-11	mic	747			uneral Ho Rd. Lando		VIA 20	1785
	23. PART i. Enter the diseases, or	complications the	at caused the	death Do	not apter the	- Dana	OVCI	de Danac	ACTI	10 20	7703
		List only one car	use on each l	ine	not anter tha	mode of dyl	ing, auch a	a cardiac or reapi	ratory arre	eat,	Approximata
	IMMEDIATE CAUSE (Final	List only one car	use on each l	ina.					ratory arre	eat,	Approximate interval Batween Onset and Daath
	IMMEDIATE CAUSE (Final	a. WETA	STAT	ina.	BREX				ratory arre	eat,	Interval Batween
7	IMMEDIATE CAUSE (Final	a. WETA	use on each l	ina.	BREX				ratory arre	eat,	Interval Batween
rion	IMMEDIATE CAUSE (Final	a. WETA DUE TO	STAT	ine.	SREA FI:				ratory arre	eat,	Interval Batween
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BALTIMORE, MARYLAND 21215-0020	I hours after dearth. Page 6 may be retained by the hospital or attending physician.	THE EUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	e medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ze hours after death. Page 6 may be retained by the hospital or attending physician.	THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the I the filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	REGISTRAR 1. DECEDENT'S NAME (First, Middle, Last)		CI	EKIIF	CATE	OF	DEA			REG. NO.			
	Ronald		MANCARR	ELLA					2. DATE	of DEATH	11, 1	995	10:35 PM
	4. SOCIAL SECURITY NUMBER 044-12-2443	5. SEX 1 X M 2 F	6. AGE (In yrs. In:	yns.	IF UNDER 1	YEAR DAYS	# UNDER	MIN.	(Monti	OF BIRTH n, Day, Year) . 3 192:	3	Country	PLACE (State or Foreign v) NECTICUT
TOR	90. FACILITY NAME (If not institution, give DOCTOR S HOSPITA RESIDENCE OF DECEDENT			T.	96. CITY, 1			ON OF DEA			9c. COUN	ITY OF DI	
DIRECTOR		CE GEORGE			r, town or ADENB		ON						10d. INSIDE CITY LIMITS? 1 TYPES 2 NO
FUNERAL	100. STREET AND NUMBER 5535 VOLTA AVENU	JE					21P CODI	Ē			10g. CITIZ		HAT COUNTRY?
ВУ	11. MARITAL STATUS 1 Never Married 2 Merried 3 W Widowed 4 Divorced	12. WAS DECEDENT FORCES? 15 IF YES, GIVE WA	EVER IN U.S. AF YES 2 1 FOR DATES	RMED NO	H	yes, spe	city Cube	F HISPANIO n, Maxican, Specify:	ORIGIN Puerto I	7 (Specify Yea Rican, etc.)		14. RACE	
COMPLETED	15. DECEDENT'S EDI (Specify only highest grad Elementary/Secondary (0-12) 11TH	UCATION le completed) College (1-4 or 5+)	(G life	CEDENT'S live kind of w Do NOT us	rork done du e retired.)	UPATIO	N t of workin	ng		NAVAIL		USTRY	
BE CON	17. FATHER'S NAME (First, Middle, Last) UNAVAILABLE							HER'S NAMI	E (First, I	Aiddle, Maiden S			
10	196. INFORMANT'S NAME (Type/Print) 196. MAILING AODRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) STAN DIXON 5535 VOLTA AVENUE, BLADENBURG, MD 20710 206. METHOD OF DISPOSITION 206. PLACE AND DATE OF DISPOSITION (Name of DATE DATE) 206. LOCATION — City or Town, State												
	20e. METHOD OF DISPOSITION 1	month of the later			VIRGI	NIA	CREI		YOC				ON, VA.
	· nus	Ba	a_	2 76	W. 34	H. 1	BACO 14TH	STRE	ERA	L HOME	ASH, D	.C.	20010
	23. PART I. Enter the diseases, or shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death)	e. Card	ac A		25t	ne mod	le of dyl	ng, such	aa carc	liac or reapin	atory arre	eat,	Approximate Interval Betwee Onset and Deat
ERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury C. C. C. C. C. C. C. C. C. C. C. C. C.											Fday	
CERTIF	that initiated events resulting in death) LAST	DUE TO (0	OR AS A CONSE	OUENCE OF	7):								
MEDICAL	PART II. Other algnificent condition						Couse (jiven in P	ert I.	24s. WAS AN A PERFORM	MED?	24b.	WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
PHYSICIAN:	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	RIBUTE TO CAL		TH YE			UNC	ERTAIN					
BY PHYS	1 VES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	1 N Inpetient 2 -	NJURY	28b. TIMI	4 Nursir	Bc. INJU	RY AT			(Specify)	JURY OCC	URED	
COMPLETED B	3 Suicide 8 Could not be determined 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 28e. PLACE OF INJURY — At home, ferm, street, factory, office City or Town, Stete)									oute Number,			

BE

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29b. SIGNATURE AND TITLE OF CERTIFIE 29c. LICENSE NUMBER

D20302

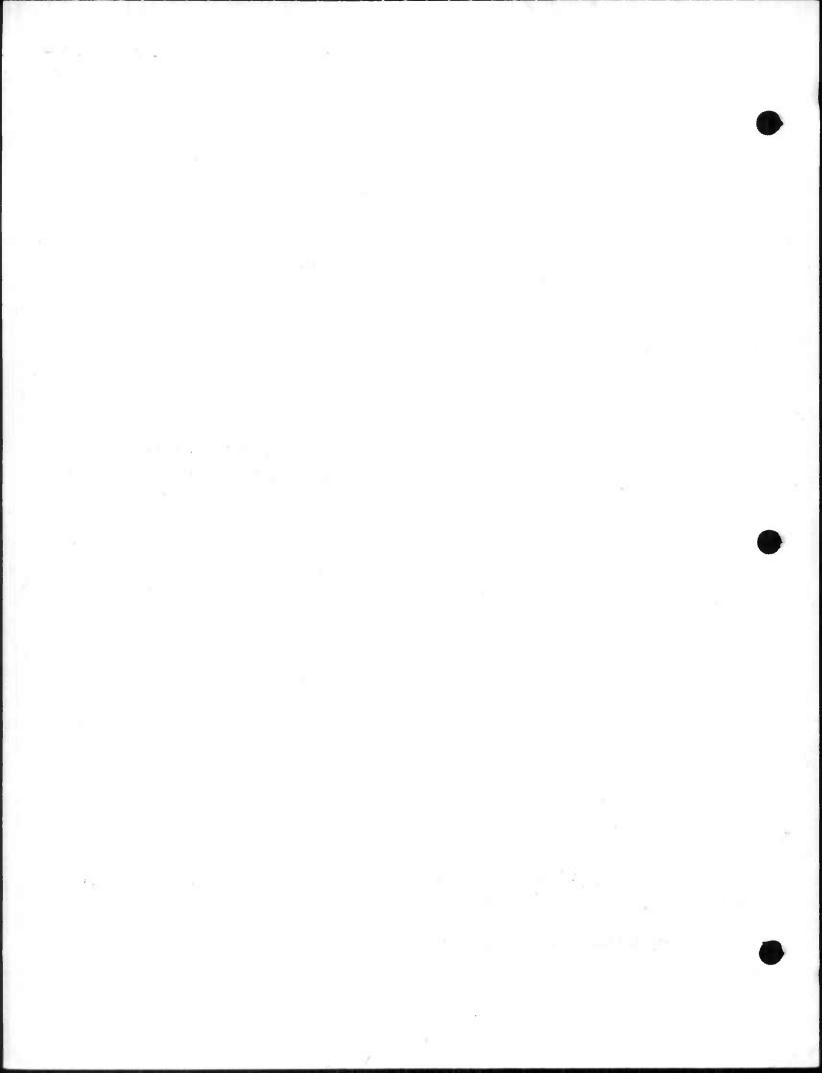
29d. DATE SIGNED (Month, Day, Year) 16/12/95

30. NAME AND ADDRESS OF PERSON WHO DAY.

Dr. Robert Gereige 2 44 0 74th Avenue Landover Hills, MD 20784

31. DATE FILED (Month, Day, Year) NOV 03 1995

32, REGISTRAR'S SIGNATURE



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DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death centificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this centificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlat-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlat, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be netfled at once.

1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REG. NO.

1. DECEDENT'S NAME (First, Middle, Last)

2. DATE OF DEATH DAY MONTH

	nedio man				OLITIT	TOATE	DEAL	0.0	ned. NO			
	1. DECEDENT'S NAME (First	, Middle, Last)							2. DATE OF DEATH	.w	YEAR 3. TIR	ME OF DEATH
	Henry Mcau	iro							10 23			37 am M
	4. SOCIAL SECURITY NUM		5, SEX	6. AGE (In yrs.	last hirthday)	IF UNDER 1 YEA	R IF UNDER	24 MRS	7. DATE OF BIRTH			(State or Foreign
	4. 00 OFFIC DECORATE FROM	2011				MONTHS DAY		MIN.	(Month, Day, Year)		Country)	(Citate of Foreign
	427-12-174	6	1 X M 2 □ F	82	YRS.				3/15/13	E	laine,	Arkansas
	9a. FACILITY NAME (If not in	nstitution, give st	reet and number)			9b. CITY, TOV	N OR LOCATIO	ON OF DE	ATH	9c. COUNT	Y OF DEATH	
r	Holer Cro	aa Hoay	14-1			51	IED S	50	ciala	Mont	~~~	
CIOR	Holy Cro	SS HUS	ortar			111	CK.	1	11106	Mont	gomery	
1)	10a. STATE	10b. COUNTY			10c. CIT	Y, TOWH OR LO	CATION					NSIDE CITY
DIE	MD	Montos			C.	1 C						LIMITS?
	MD	Montgo	mery		51	lver S				_		YES 2 NO
Z I	100. STREET AND NUMBER						101. ZIP CODE	E		10g. CITIZI	EN OF WHAT C	OUNTRY?
FUNERAL	14005 Cas	tle Box	llevard	#304			200	904			USA	
Z	11. MARITAL STATUS	OIC DO	12. WAS DECEDEN	17-0-	ARMED	13 WMS		_	IIC ORIGIN? (Specify Yes			nerican indian,
I	1 Never Married 2	Married		YES 2	XNO	It yes	, specify Cubsi	n, Maxica	n, Puarto Rican, etc.)		Black, White	a, atc.
B	3 Widowed 4 X Dive		IF YES, GIVE V	MAR OR DATES		1 🗆	YES 2X NO	Specify	<i>f</i> :		Specify: E	Black
ED		CEDENT'S EDUC ly highest grade		16a.	(Give kind of	Work done during		107	16b. KIND OF BU	SINESS/INDU	ISTRY	
Ä,	Elementary/Secondary (0-12)	College (1-4 or 5	+)	ille. Do NOT u	se retired.)			10 1	c +	- 1	
COMPL	12				Labor	or			Del-	- 6	mplo.	UFD.
2	17. FATHER'S NAME (First, A	Alddle, Lest)					18. MOTE	HER'S NA	ME (First, Middle, Malden		1	
							101 1110 11		, , , , , , , , , , , , , , , , , , , ,		'	
B E	Paul McGu								tte Crawfo			
0	19a. INFORMANT'S NAME (Type/Print)							Route Number, City or Tox			
Ĕ	Charlotte 1	Donica	Matter		14005	Castle	e Boule	evar	d Silver	Sprin	g, MD	20904
	20a. METHOD OF DISPOSIT		Walton_	20h DI 4	CE AND DATE	OF DISPOSITIO	4 /Nome of			-	Ity or Town, St	ete
	1 X Burist 2 - Cremeti	on 3 D Remo	oval from State		, cremetory or a		I (Matthe Ot					
	4 Donation 5 Othe			Gle	nwood	Comete	rv	10	0/27/95 V	Vashin	gton,	DC
	21. BIGHATURE OF TONER	AL SERVICE LIC	MSEE		7202							
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	Sylthe	1	som			563	5 Fads	Str	eet NE V	Jash.	DC 2	20019
	23. PART Enter the cannot shock, or t	diseason, or f	opplications the	y chused the	death. Do	not enter the	mode of dyl	ing, auc	h aa cardiac or reap	iratory arre	at,	Approximate
	II .	•	Dnly one ca	e on each	line.							Oneet and Death
	IMMEDIATE CAUSE (FI disease or condition	nai	1	11011	A. 11	1. Ma	1/A1	4	1115	CY		
	resulting in death)	→ :	· U	1/1/10	1010	07.007	2/1/	1	ARRE	>1		1 hush
			DUE TO	OR AS A CON	ISEQUENCE O)FI:					_	
7			COR	UNI	114	A	TER	4 1	115EAS	=		20,00B
CATION	Sequentially list condi		DUE TO	OR AS A CON	NSEQUENCE O	OF):		1				
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	that initiated events		DUE IC	(OH AS A COR	42EOUENCE C	<i>P</i> =}:					i	
CERTIFI	resulting in death) LAS		d									
				Trans.								
EDICAL	PART II. Other algnific	ent condition	a contributing to	deeth but n	Dt reaulting	in the under	lying cause of	given in	Part I. 24e. WAS AP PERFO			ABLE PRIOR TO
ರ									t _ YES			PLETION OF CAUSE EATH?
Σ		INT COLUM		LUCE OF D	E 4711 10	D 110	- unio	20074			10	YES 2 NO
Ż	DID TOBACCO U	12F COMII	KIBUTE TO CA			ES NO		ERTAI	N MZ			
×	25. WAS CASE REFERRED	TO MEDICAL		26. P	PLACE OF DEA	ATH (Check only	one)					
SICIAN:	EXAMINER?		HOSPITAL:	ER/Outnation	n 3 🗆 DOA	OTHER:	Home & 🗆 🖦	esidence	S Other (Specify)			
H	27, MANNER OF DEATH		28a, DATE O		28b. Til		. INJURY AT	31001100	28d. DESCRIBE HOW	IN HIRY OCC	URED	
4		Pending		Day, Year)	IN	JURY	WORK?		200. DESCRIBE NOW	INJUNI OCC	OHED	
BY	2 Accident	investigation				M 1	YES 2	NO				
	3 Suicide 8	Could not be	28e. PLACE	OF INJURY - A	It home, farm,	atreet, factory,	office		28f. LOCATION (Street		or Rural Route I	lumber,
ш	4 Homicide	determined	ballaring	, etc. (Specify)					City or Town, State	,		
COMPLETED	-											
2	29a. CERTIFIER (Check only	TIFYING PHYSI	CIAN: To the best of	of my knowledge	e, death occur	red at the time,	data and place	, and dua	to the cause(a) and me	nner sa state	d.	
Σ	ana)	DICAL EXAMINE	R: On the basis of	exemination and	d/or Investigati	lon, in my opini	on, death occur	red at the	time, data and place, a	nd due to the	cause(s) and	menner as stated.
ဗ္ဗ												
B H	296. SIGNATURE AND TUTL	E OF CERTIFIE	00	4	1		29c. LIC	ENSE NUI	MBER	29d. DATE	SIGNED (Mont	h, Day, Year)
	Merke	46.1	116Cos	no	7/		1	2-10	115	- /	0/23	195
2	30. NAME AND ADDRESS (OF PERSON WH	O COMPLETED CAL	USE OF DEATH	(ITEM 27) (TVD	e, Print)	- //				1	(
	11-1-1 -11			1	10		101.		le dd	CC	M.O	
	MECTUL	(1. (016150	NM	1	840	(olas	· V//	1-e na	17 /	-2	
	31. DATE FILES (Man), O	71005	32 ABGISTA	AB'S SIGNATUR	M.L.M							
	901 6	1222	June		-							

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Pyram = my MALLZ 130

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withing how in a fler death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	TE OF MARYLAND / I	DEPARTME RTIFICA				ENTAL HYGIEN	E	
	1. DECEDENT'S NAME (First, Middle, Lest)					T	2. DATE OF DEATH		3. TIME OF DEATH
	Maxine Moore O'Ne						October 6		1118 hrs "
	4. SOCIAL SECURITY NUMBER 5. SEX		MONT	HS DAYE	IF UNDER 2	MIN.	7. DATE OF BIRTH (Month, Day, Year)	Con	TTHPLACE (State or Foreign untry)
	219-44-1821 1 🗆 h	2X F 81	YRS.	CITY, TOWN O	D I OCATIO		ecember 8,	1913 Mai	
DIRECTOR	Magonoia Hall Nursin				stert		in .	Kei	
REC	10a. STATE 10b. COUNTY		10c. CITY, TOW	VN OR LOCAT	ION				10d. INSIDE CITY
	Maryland Queen A	nnes			lersv				1 YES 2 XXO
FUNERAL	611 Leager Road			101.	ZIP CODE	2166	0		F WHAT COUNTRY?
S	11. MARITAL STATUS 12. WAS	S DECEDENT EVER IN U.S. ARM	ED	13. WAS DEC	ENDENT OF	F HISPANIC	ORIGIN? (Specify Yea	or No.— 14, R/	States
BY F		RCES? 1 TYES 2X NO ES, GIVE WAR OR DATES		If yes, spe	elty Cuban 2X NO	, Maxican,	Puerto Rican, etc.)	Sp	ack, White, atc.
	15. DECEDENT'S EDUCATION	16a. DECI	EDENT'S USUA	L OCCUPATIO	N		t6b. KIND OF BUS		White
Ē,	(Specify only highest grade complete Elementary/Secondary (0-12) Colleg	d) (Give	kind of work do NOT use retire	one during mos	st of working	7			
COMPLETED	9	Home	maker					ic / Own	n Home
	17. FATHER'S NAME (First, Middle, Last) Joseph Merritt Legar						E (First, Middle, Malden		
BE	19a. INFORMANT'S NAME (Type/Print)		MAILING ADDR	IESS (Street ar			Emma Taylo		
10	Richard O'Neal						rsville, l		1 21668
	20a. METHOD OF DISPOSITION 1 X Burial 2 Cremation 3 Removal from	n State cemetery cremi	ID DATE OF DISI	ce1		_	1	CATION — City or	
	4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSE	Galena	Cemet	ery - 22. NAME AN	OCTO D ADDRESS	ber	9, 1995 G	alena, Ma	ryland
	▶ William L. Kin	Am I- Len					eral Hom		
	23. PART I. Enter the diseases, or complication		th. Do not en	3/0 Cy	pres	s St	reet, Mil	Lington.	Maryland Approximate
	shock, or heart fellure. List onl IMMEDIATE CAUSE (Finel	y one cause on each line.						atory arroat,	Interval Between Onset and Daath
		CMCMACUA DUE TO (OR AS A CONSEQU	Review	ne 10	KC11	Den)			
ľ		DUE TO (OR AS A CONSEQU	ENCE OF):						
CERTIFICATION	Sequentielly list conditions, if any, leading to immediate	DUE TO (OR AS A CONSEQU	ENCE OF):						
CAT	csuse. Enter UNDERLYING CAUSE (Disesse or Injury		_						
THE	thet initiated events resulting in deeth) LAST	DUE TO (OR AS A CONSEOU	ENCE OF):						
E	d								
AL.	PART II. Other significent conditions contri	buting to deeth but not rec	sulting in the	underlying	ceuee gl	iven in Pe	ort I. 24a. WAS AN. PERFOR		4b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO
PHYSICIAN: MEDICAL							1 YES 2	□ NO	OF DEATH?
: W	DID TOBACCO USE CONTRIBUTE	TO CAUSE OF DEAT	H YES T	1 NO 17	LINCE	RTAIN	_		1 Tes 2 No
NA I	25. WAS CASE REFERRED TO MEDICAL	26. PLACE	OF DEATH (Che		OITCL	KIMIN			
YSIC	1 ☐ YES 2 NO t ☐ Inp	PITAL: estlant 2 ER/Outpatient 3 E	DOA 4X		5 🗆 Raei	Idence 6	Other (Specify)		
ВУ РН	27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	Month, Day, Year)	28b. TIME OF INJURY	26c. INJU WOI 1 Y	NY?		ed. DESCRIBE HOW IN	JURY OCCURED	
COMPLETED		n. PLACE OF INJURY — At home building, etc. (Specify)	e, farm, street,	factory, office		2	8f. LOCATION (Street a City or Town, State)	nd Number or Run	il Route Number,
PE	29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To	the best of my knowledge, deat	h occurred at II	ne time, data	and place, a	and dua to	the cause(a) and man	ner as stated.	
O	one) 2 MEDICAL EXAMINER: On the								e(s) and manner as stated.
BEC	29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICEN				ED (Month, Day, Year)
6	30. NAME AND ADDRESS OF PERSON WHO COMPL	CUS			17-1	3829	f	10-	11-95
	WHO COMPL	ETED CAUSE OF DEATH (ITEM)	Z/) (Type, Print)						
/ 1		REGISTRAR'S SIGNATURE				-			
0	OCT 12 '95 Stut	ia Davidson-Randa	02						
	17								

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

31. DATE FILED (Month, Day, Year) OCT 251995

William

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3 should	E	90. FACILITY NAME (# not in 12440 White							R LOCATION OF DE	ATH			ONT	TH
1, 2,	ECTO	RESIDENCE OF DECEDENT					Dunkirk					Calvert		
permit. Pages	OF 1	Maryland Calvert				10c. CITY, TOWN OR LOCATION Dunkirk								M. INSIDE CITY LIMITS? YES 2 \(\text{\ballet} \) NO
sit permit	ERAL	100. STREET AND NUMBER 12440 Whit		Ct.					20754			USA	EN OF WH	AT COUNTRY?
ding physician.	BY FUN	11. MARITAL STATUS 1 Never Married 2 3 Widowed 4 Divo	-	12. WAS DECEDENT FORCES? 1 IF YES, GIVE W		RMED NO	- 11	yes, spe	ENDENT OF HISPAN point Cuban, Maxica 2 A NO Specify	n, Puerto I	? (Specify Yes Rican, etc.)		Black, \	American Indian, White, etc.
r attending use as the	ETED		CEDENT'S EDU ly highest grad			Give kind of	work done di	CUPATIO	N st of working	16b	KIND OF BUS	HNESS/INDU	STRY	
Q = 1	PLE	Elementary/Secondary (12th	0-12)	College (1-4 or 5+)	%. <i>Do NOT u</i> e 1f- еп		ed		N	ursery	man		
물 등 등	COMPL	17. FATHER'S NAME (First, A		nolon					18. MOTHER'S NA		Middle, Maiden	Sumame)		
d by	88	Roger Bain		rsiei					Mabel I					
retained 5 should notified	5	Gloria P. C		.	1				nd Number or Rural I	Route Numb	ber, City or Town	n, Stete, Zip (Code)	
2 8 8		29a. METHOD OF DISPOSIT		same				1						
		1. Burial 2 Cremate 4 Donation 5 Other		LACEAND DATE OF DISPOSITION (Name of Parketory or other place) and the place of the										
death. Page 6 m funeral director,		21. SIGNATE FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY GEORGE P. Kalas									neral	Home		
2 2 3		the	P.K.	da V					xon Hill				Md.	20745
ited within 24 hours after completely filled in by the rial, cremation, or removal cevent, the medical		23. PARTY Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or reepiratory arrest, shock, or heart failure. List only the cause on asch line. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF):											Approximate interval Betwee Onset and Date I NSTAR	
th certificate be executed tending physician and con al Hygiene prior to burial, or other traumatte et	ERTIFICATION	Sequentially list condi- if any, leading to imme cause. Enter UNDERLY CAUSE (Disease or inj- that initiated events resulting in death) LAS	odleta ring ury	b. DUE TO	OR AS A CONS	EOUENCE O	F):		<i>V</i>					YEARS
s that the death gned by the atter aith and Mental	EDICAL C	PART II. Other algnific	ent conditio	na contributing to	death but no	t reaulting	in the un	deriying	g ceuze given in	Part i.	24a. WAS AN PERFOR	MED?	6	VERE AUTOPSY FINDING WAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
v requires been sign rt. of Heal	Σ	DID TOBACCO U	JSE CON	TRIBUTE TO CA	USE OF DE	ATH Y	ES 🗆 N	NOZ	UNCERTAIL	v 🗆 .			1	YES 2 NO
2 Sep 2	IAN	25. WAS CASE REFERRED				ACE OF DEA								
M: The ficate h State State	SIC	EXAMINER?		HOSPITAL:	ER/Outpatient	3 DOA	OTHER	t: ing Hom	e 5 XResidence	8 Othe	er (Specify)			
NG PHYSICIAN: The fler this certificate h eath with the State I marked, or Item	PHYSICI	27. MANNER OF DEATH	Pending	28a. DATE OF (Month, De	INJURY	28b. TIN		28c. INJ WO			SCRIBE HOW I	NJURY OCC	URED	
TTENDING TOR: After after deatt	TED BY	2 Accident 3 Suicide 6 4 Homicide	Could not be determined	28e. PLACE Of building,	F INJURY — At artc. (Specify)	- At home, farm, atreat, factory, office 28f. LOCATION (Street			CATION (Street or Town, State)	et and Number or Rural Route Number, ite)		ute Number,		
世 弘 元 申	OMPLET			SICIAN: To the beat of										and manner as stated
THE HOSPI THE FUNER filed within	8	29b. SIGNATURE AND TITL	E OF CERTIF	ęn					29c, LICENSE NUI	MBER		29d, DATE	SIGNED (Month, Day, Year)
五五五多	8		h	4					ກລາ	65	7	1	0/23	3/94
5 5 3 X	2	30. NAME AND ADDRESS O	OF PERSON W	HO COMPLETED CAUS	SE OF DEATH (I	TEM 27) (Type	e, Print)		1)0.		/		10.0	, ,

Oursler

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE **CERTIFICATE OF DEATH**

YEAR

Charles Judge, M.D. 10331 Southern Maryland Blvd. Dunkirk, Md. 20754

SE REGISTRAT'S SIGNATURE

3. TIME OF DEATH

Approximate interval Between Onset and Death

INSTART

24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?

9:41

8. BIRTHPLACE (State or Foreign

REG. NO.

October 23, 1995

2. DATE OF DEATH MONTH DAY

7. DATE OF BIRTH 2727721

DHMH-16 Rev 1/89

Walter Care Street

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

THE MISSING OF ATTENDING PROJUCIAN. The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	THE PLINE ALL DIPECTION Are this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit nermit. Places 1, 2, 3 should	Med within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	PORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HOSPITAL	TO THE FUNERAL	Se filed within 72	IMPORTANT: IF

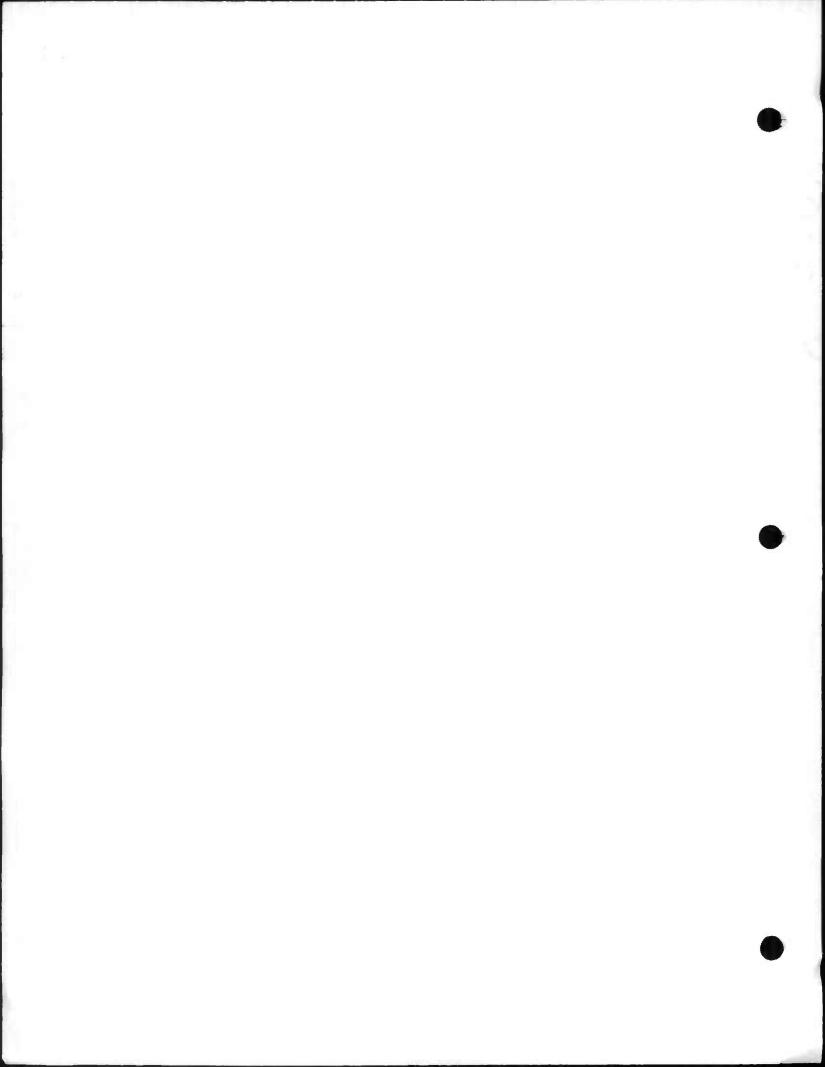
								90	33992	
	FOR 1 . STATE	STATE OF MARY	LAND / DEPAR	RTMENT OF I	TEALTH AND	MENTAL	. HYGIEN	E		
	REGISTRAR 1. DECEDENT'S NAME (First, Middle, Last)		CERTIF	ICATE OF	DEATH		REG. NO			
	MARY FRANCES PHI					MONTH	_		YEAR 3. TIME OF DEAT	H
	4. SOCIAL SECURITY NUMBER		E (In yrs. last birthday)			10	20			PM
	213-42-2290	1 M 2 X F	89 YRS.	MONTHS DAYS	HOURS MIN.	(Month	Dey, Year)		8. BIRTHPLACE (State or Fo Country)	reign
	9a. FACILITY NAME (If not institution, give	2.5	09 THS.	2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2			27,		MARYLAND	
Œ	DORCHESTER GENER				OR LOCATION OF D	EATH			TY OF DEATH	
18	RESIDENCE OF DECEDENT	AL HOSPITAL		CAMBRI	DGE			DORG	CHESTER	
DIRECTOR	10a. STATE 10b. COUNT	Y	10c. CIT	Y, TOWN OR LOCA	TION				10d. INSIDE CITY	
5	MARYLAND DOR	CHESTER	V	/IENNA					LIMITS?	NO
AL.	10e. STREET AND NUMBER			10	f. ZIP CODE			10g. CITIZ	EN OF WHAT COUNTRY?	
띮	107 CHURCH STREE	Γ			2186	9		USA	A	
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT EVER FORCES? 1 YE	IN U.S. ARMED	13. WAS DEC	ENDENT OF HISPA	NIC ORIGIN	(Specify Ver	or No-	14. RACE — American India Black, White, etc.	in,
BY	1 Never Married 2 Merried 3 X Widowed 4 Divorced	IF YES, GIVE WAR OR		1 TYPES	ecify Cuban, Maxica 2 NO Specif	y:	ican, atc.)		Specify:	
	15. DECEDENT'S EDU	10.770	The Handson						WHITE	
12	(Specify only highest grad	e completed)	(Give kind of v	USUAL OCCUPATION Work done during mo	ON ost of working	16b.	KIND OF BU	SINESS/INDU	JSTRY	
1 2	Elementary/Secondary (0-12)	College (1-4 or 5+)		MAKER						
COMPLETED	17. FATHER'S NAME (First, Middle, Last)		110112	A MINCELL	18. MOTHER'S NA	ME (First M	iririla Mairian	Sumama)		
U U	JASPER LEE THOMP	SON			MARY F			,		
0	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street a	and Number or Rural	Route Numb	er. City or Tow	n. Stein. Zio (Code)	
유	MARY FRANCES SPE	AR			, VIENNA					
	20a. METHOD OF DISPOSITION 1 X Burlal 2 Cremation 3 Rem	2	06. PLACE AND DATE	OF DISPOSITION (Ne	ame of	OATE	7	CATION — C	Ity or Town, State	
	4 Donation 6 Other (Specify)	E	AST NEW M	ARKET C	EMETERY	10/	25 EAS	T NEW	MARKET, MI)
	21. SIGNATURE OF FUHERAL SERVICE LI	CENSEE	111		ND ADDRESS OF FA					
	Lemand	Che Sik	les	ZELLEI	R FUNERAL	L HOM	E, P.	O. BO	OX 207,	
	23. PART I, Enter the disesses, or	complications that caus	ed the death. Do r	not enter the mo	de of dying, suc	h as cardi	SC or respi	ratory srre	RKET, MD 216	
	shock, or heart feiture. IMMEDIATE CAUSE (Final	List only one cause on	esch line.		,			•	Interval Be Onset and	etween
	disesse or condition resulting in death)	· RPDDI	aton	P F00	lure				30	165
	Tourist of Carry	DUE TO (OR AS	A CONSEQUENCE O	h:	·ui					M and
Z	Sequantially list conditions,	b								
ERTIFICATION	if sny, isading to immediate cause. Enter UNDERLYING	DUE TO (OR AS	A CONSEQUENCE OF	F):						
길	CAUSE (Disease or Injury	C	A CONSEQUENCE OF							
Ē	that initiated events resulting in death) LAST	DOE TO (OR AS	A CONSEQUENCE OF	-):						
CEI		d								
AL	PART II. Other significant condition	na contributing to death	but not resulting	n the underlyin	g cause given in	Part I.	24a. WAS AN PERFOR		24b. WERE AUTOPSY FIL	
MEDICAL						_	1 YES 2		AVAILABLE PRIOR 1 COMPLETION OF C	
ME						[1 TES 2 N	10
	DID TOBACCO USE CONT	RIBUTE TO CAUSE			UNCERTAIL	N				
C	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEAT	OTHER:						
Z	1 YES 2 NO	1 Inpetient 2 - ER/Ou		4 - Nursing Hom	e 5 🗆 Realdence	6 🗆 Other	(Specify)			
		28a. DATE OF INJURY		URY WO	RK?	28d. DE\$0	RIBE HOW I	NUTRY OCCU	JRED	
PHYSICIAN:	27. MANNER OF DEATH 1. Netural 5 Pending	(Month, Day, Year)								1
BY PH	1 Natural 5 Pending 2 Accident Investigation				YES 2 NO					
ED BY	1 Natural 5 Pending	(Month, Day, Year) 28a. PLACE OF INJUF building, atc. (Sp	RY — At home, farm, e			281. LOCA City o	TION (Street a	nd Number o	or Bural Route Number,	
ED BY	1 Netural 5 Pending 2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide determined	28a. PLACE OF INJUF building, atc. (Sp	ecity)	street, factory, offic	•	City o	Town, State)	7.7		
ED BY	1 Netural 2 Accident 3 Suicide 4 Homicide 29e. CERTIFIER (Check only) 5 Pending Investigation 5 Could not be determined	28e. PLACE OF INJUR building, atc. (Sp ICIAN: To the best of my kno	ecity) wledge, death occurre	street, factory, offic	and place, and due	to the caus	•(e) and mar	ner an atatec	d.	
ED BY	1 Netural 2 Accident 3 Suicide 4 Homicide 8 Could not be determined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINI	28a. PLACE OF INJUI building, atc. (Sp iiClAN: To the best of my kno ER: On the basis of examinat	ecity) wledge, death occurre	street, factory, offic	and place, and due	to the caus	•(e) and mar	ner an atatec	d.	ated.
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BE COMPLETED BY	1 Netural 2 Accident 3 Suicide 4 Homicide 29e. CERTIFIER (Check only one) 29b. SIGNATURE AND TITLE OF CERTIFIE WALLIAM 5 Pending Investigation 8 Could not be determined 7 CERTIFYING PHYS 2 MEDICAL EXAMINI	28a. PLACE OF INJUR building, atc. (Sp IICIAN: To the best of my kno ER: On the basis of examinate	ecity) wiedge, death occurre ion and/or investigatio	street, factory, officed at the time, date on, in my opinion, d	e and place, and due eath occured at the	to the caus	•(e) and mar	ner as stated	d, cause(a) and manner as st	ated.
E COMPLETED BY	1 Netural 2 Accident 3 Suicide 4 Homicide 29e. CERTIFIER (Check only one) 29b. SIGNATURE AND TITLE OF CERTIFIE WALLIAM 5 Pending Investigation 8 Could not be determined 7 CERTIFYING PHYS 2 MEDICAL EXAMINI	28a. PLACE OF INJUI building, atc. (Sp iiClAN: To the best of my kno ER: On the basis of examinat	wiedge, death occurre	ord at the time, date	and place, and due eath occured at the 29c. LICENSE NUI	to the cause time, data a	r Town, State) e(e) and mar	d due to the	d. cause(a) and manner as st SIGNED (Majnth, Day, Year)	
BE COMPLETED BY	1 Netural 2 Accident 3 Suicide 4 Homicide 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINI 29b. SIGNATURE AND TITLE OF CERTIFIE 30. NAME AND ADDRESS OF PERSON WITHOUT AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WITHOUT AND TITLE OF CERTIFIER 31. NAME AND ADDRESS OF PERSON WITHOUT AND TITLE OF CERTIFIER 32. NAME AND ADDRESS OF PERSON WITHOUT AND TITLE OF CERTIFIER 33. NAME AND ADDRESS OF PERSON WITHOUT AND TITLE OF CERTIFIER 34. NAME AND ADDRESS OF PERSON WITHOUT AND TITLE OF CERTIFIER 35. NAME AND ADDRESS OF PERSON WITHOUT AND TITLE OF CERTIFIER 36. NAME AND ADDRESS OF PERSON WITHOUT AND TITLE OF CERTIFIER 36. NAME AND ADDRESS OF PERSON WITHOUT AND TITLE OF CERTIFIER 36. NAME AND ADDRESS OF PERSON WITHOUT AND TITLE OF CERTIFIER 36. NAME AND ADDRESS OF PERSON WITHOUT AND TITLE OF CERTIFIER 37. NAME AND ADDRESS OF PERSON WITHOUT AND TITLE OF CERTIFIER 38. NAME AND ADDRESS OF PERSON WITHOUT AND TITLE OF CERTIFIER 39. NAME AND ADDRESS OF PERSON WITHOUT AND TITLE OF CERTIFIER 39. NAME AND ADDRESS OF PERSON WITHOUT AND TITLE OF CERTIFIER 39. NAME AND ADDRESS OF PERSON WITHOUT AND TITLE OF CERTIFIER 39. NAME AND ADDRESS OF PERSON WITHOUT AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WITHOUT AND TITLE OF CERTIFIER 39. NAME AND ADDRESS OF PERSON WITHOUT AND TITLE OF CERTIFIER 39. NAME AND ADDRESS OF PERSON WITHOUT AND TITLE OF CERTIFIER 39. NAME AND ADDRESS OF PERSON WITHOUT AND TITLE OF CERTIFIER 39. NAME AND TITLE OF CERTIFIER 39. NAME AND TITLE OF CERTIFIER 39. NAME AND TITLE OF CERTIFIER 39. NAME AND TITLE OF CERTIFIER 39. NAME AND TITLE OF CERTIFIER 39. NAME AND TITLE OF CERTIFIER 39. NAME AND TITLE OF CERTIFIER 39. NAME AND TITLE OF CERTIFIER 39. NAME AND TITLE OF CERTIFIER 39. NAME AND TITLE OF CERTIFIER 39. NAME AND TITLE OF CERTIFIER 39. NAME AND TITLE OF CERTIFIER 39. NAME AND TITLE OF CERTIFIER 39. NAME AND TITLE OF CERTIFIER 39. NAME AND TITLE OF CERTIFIER 39. NAME AND TITLE OF CERTIFIER 39. NAME AND TITLE OF CERTIFIER 39. NAME AND TITLE OF CERTIFIER	28a. PLACE OF INJUING BUILDING STORY AND STORY	wiedge, death occurre ion and/or investigatio EATH (ITEM 27) (Type,	ord at the time, date	e and place, and due eath occured at the	to the cause time, data a	r Town, State) e(e) and mar	d due to the	d. cause(a) and manner as st SIGNED (Majnth, Day, Year)	
BE COMPLETED BY	1 Netural 2 Accident 3 Suicide 4 Homicide 29e. CERTIFIER (Check only one) 29b. SIGNATURE AND TITLE OF CERTIFIE WALLIAM 5 Pending Investigation 8 Could not be determined 7 CERTIFYING PHYS 2 MEDICAL EXAMINI	28a. PLACE OF INJUR building, atc. (Sp IICIAN: To the best of my kno ER: On the basis of examinate	wiedge, death occurre ion and/or investigatio EATH (ITEM 27) (Type,	ord at the time, date	and place, and due eath occured at the 29c. LICENSE NUI	to the cause time, data a	r Town, State) e(e) and mar	d due to the	d. cause(a) and manner as st SIGNED (Majnth, Day, Year)	

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IR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be	RECTOR: After this certificate has been signed by the attending obvision and completely filled in by the funeral diseases
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FOR STATE REGISTRAR	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND CERTIFICATE OF DEATH	MENTAL HYGIENE REG. NO.
1. DECEDENT'S NAME (First, Middle, Last)		2. DATE OF DEATH
Gladys Beatrice	Parks	Coother 26 19

					ERITE	SAIL U	F DEAL	п	REG. NO			
	1 2	1. DECEDENT'S NAME (First, Middle, Last							2. DATE OF DEATH MONTH DA	W	YEAR :	3. TIME OF DEATH
		Gladys Beatri	ce Parks						Ocother 26		-	845P M
		4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. is		IF UNDER 1 YEA		24 HRS	7 DATE OF BIRTH		e BIOTHO	ACE (State or Same)
		21448 0666	1 □ M 2 🔀 F	91	YRS.	ONTHS DAY	HOURS	MIN.	September 2	1904	Mar	yland
3 should	1 3	9a. FACILITY NAME (If not inetitution, give	street end number)		- 1	96. CITY, TOW	N OR LOCATIO				TY OF DEA	
	E E	Calvert Count	y Nursin	g Cent			ce Fr				vert	
1, 2,	СТОВ	RESIDENCE OF DECEDENT										
Sec	ш	10a. STATE 10b. COUN	тү		10c. CITY,	TOWN OR LO	CATION				- 1	IOd. INSIDE CITY
5	DIR	Maryland Anne	Arundel		Gale	esvil	م (LIMITS?
permit. Pages	A P	10e. STREET AND NUMBER			1002		101. ZIP CODE			10g. CITIZ		AT COUNTRY?
usit p	EB	914 Main Stree	et				20	765				States
priysician. burlal-transit	UNER	11. MARITAL STATUS	12. WAS DECEDENT	EVER IN U.S. A	RMEO	13. WAS D	ECENDENT OF	E HISDANI	C ORIGIN? (Specify Yes			- American Indian,
prysician burial-trar	L.	1 Never Married 2 Merried	FORCES? 1	YES 2	No.	If yes,	specify Cuban	s, Mexican	, Puerto Ricen, etc.)	or No-	Black, 1	White, etc.
the all	ВУ	3. Widowed 4 Divorced	ii res, dive to	NO DATES		י ויי	ES 2 NO	Specify:		- 1	Specify:	white
se as the	G	15. DECEDENT'S ED	UCATION	18e. D	ECEDENT'S US	SUAL OCCUPA	TION		16b. KIND OF BUS	INESS/INDU		
. 3	III	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4 or 5+)	, (C	Give kind of wor e. Do NOT use i	rk done during retired.)	most of working	9				
spiral sed for	르	unknown			usewi	ife			own ho	me		
detach once.	COMPL	17. FATHER'S NAME (First, Middle, Last)					18. MOTH	FR'S NAM	IE (First, Middle, Maiden	Cumamal		
2 % To	111	George MIster							e Fowler	Surramey		
Divol Divol	BE	19e, INFORMANT'S NAME (Type/Print)	-	10	h MAILING AI	DOBESS /Stan			oute Number, City or Town	- Outer Tree	2011	
Trous see oversit, rage or may be treating by the hospital of filled in the funeral director, page 5 should be detached for only or removal. Ne medical examiner must be notified at once.	임	Neligh Parks										and 21037
bage page		20s. METHOD OF DISPOSITION										
director, page		123 Burtel 2 Cremation 3 Read Donation 5 Other (Specify)	noval from State		AND DATE OF ematory or other					CATION — CI		
die die		21. SIGNATURE OF FUNERAL SERVICE L	ICENDEE	Broc	mes]	Islan	d Cem	ete		omes	121	and Mary
funeral di s. examiner	1 1		CENSEE			22. NAME	AND ADDRES	S OF FACI	Rausch	Fun	eral	Home
al to	1 1	Dra	New			4405	Broo	mes				epublic MI
or removal		23. PART I. Enter the diseases, or	complications that	caused the de	eath. Do not	enter the r	node of dyin	ng, such	sa cardiec or respi	ratory arre	at.	Approximata
T of in		shock, or neart failure	List only one ceus	e on each line	e .							intervel Between
y fill the		IMMEDIATE CAUSE (Finel disease or condition	T 0									Onset and Death
ompletely fille il, cremation, event, the		resulting in death) s. Infectious process Due to (or as a consequence of):										
5 2 - 6	- 1		0	LI	OUEHUE OF).							+ H
	CERTIFICATION	Sequentially list conditions,	DUE TO (OR AS A CONSE	OUENCE OF							2 mon16
rior dior	¥	if any, leading to immediate cause. Entar UNDERLYING	DUÉ TO (OR AS A CONSEQUENCE OF):									
he p	[CAUSE (Disease or Injury that initiated events	OUE TO (OR AS A CONSE	OUENCE OF):							
attending physician mal Hygiene prior to	E	resulting in death) LAST										İ
the attending physicial Mental Hygiene prior Ijury, or other trau												
signed by the att Health and Menta Ws any Injury,	DICAL	PART II. Other aignificant condition	ns contributing to d	leath but not	reaulting in	the underly	ng ceuse gi	iven in P				TERE AUTOPSY FINDINGS
th ar	2	Old C	VA.	GI	Tube	- feer	hi		PERFOR		C	WAILABLE PRIOR TO OMPLETION OF CAUSE
signed Health	1 123 11		,				J		_	NAO.		F DEATH?
Sh of	=	DID TOBACCO USE CONT	RIBUTE TO CAL	ISE OF DEA	TH YES	□ NO	M LINICE	DTAIN	- l		,	YES 2 NO
has Dep	₹	25. WAS CASE REFERRED TO MEDICAL	I GAG		CE OF DEATH			KIMIN				
s certificate has been in the State Dept. of H	SICIAN:	EXAMINER?	HOSPITAL:		0	THER:		tec et un				
the the	PHY	27. MANNER OF DEATH	1 Inpatient 2 I					_	Other (Specify)			
fter this ceath with marked,		1/Netural 5 Pending	(Month, Day		28b. TIME O	Υ	VORK?		28d. DESCRIBE HOW IN	JURY OCCU	RED	
After death	BY	2 Accident Investigation	95 94 105 05				YES 2	NO				
after d	요	3 Suicide 6 Could not be determined	building, e	INJURY - At ho tc. (Specify)	ome, farm, etre	et, factory, of	ice	1	26f. LOCATION (Street electry or Town, State)	nd Number or	Rural Rou	te Number,
DIRECTOR: After this hours after death with item 28 is marked												
AL DI	COMPL	(Check only CERTIFYING PHYS	ICIAN: To the best of m	ny knowledge, de	eth occurred a	et the time, de	te end place, a	and due to	the cause(e) and man	ner as stated	j.	
FUNERAL WITHIN 72 F	õ	one) 2 MEDICAL EXAMIN	ER: On the basis of exa	mination end/or	investigation, i	in my opinion,	death occured	d at the tie	me, date end place, end	due to the	cause(s) e	nd manner ee stated.
M with	В	29b. SIGNATURE AND TITLE OF CERTIFIE					29c. LICEN					lonth, Day, Year)
TO THE FUNERA be filed within 7	0	Amolula.	mo					475		D //		
F 0 =	유	30. NAME AND AODRESS OF PERSON W	O COMPLETED CAUSE	OF OEATH (ITE	M 27) (Type. Pri	int)		113	10	/0	121	7/95
		Molouski MD 110 Hosp	ital Rd. Pri	nce Free	erick,M	D 20678						
		31, DATE FILED (Month, Day, Year)				_						
		OCT 3 0 19	32. REGISTRAR	aucusi-A	ardalle							
		9 - 10	U									

a



BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician.

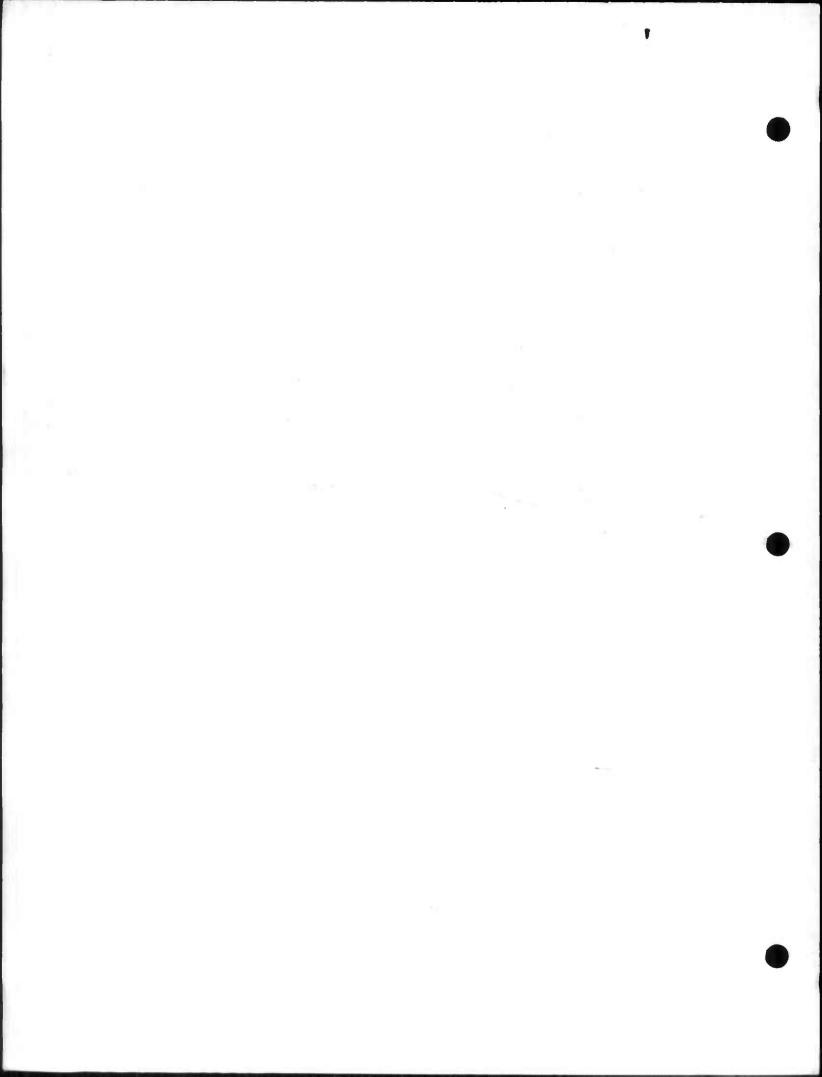
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If tem 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TEMS:	23	PART	Ι,	27,	28a-f,	PER	MEO	FILM	G-729	11/17/9	35 t.t

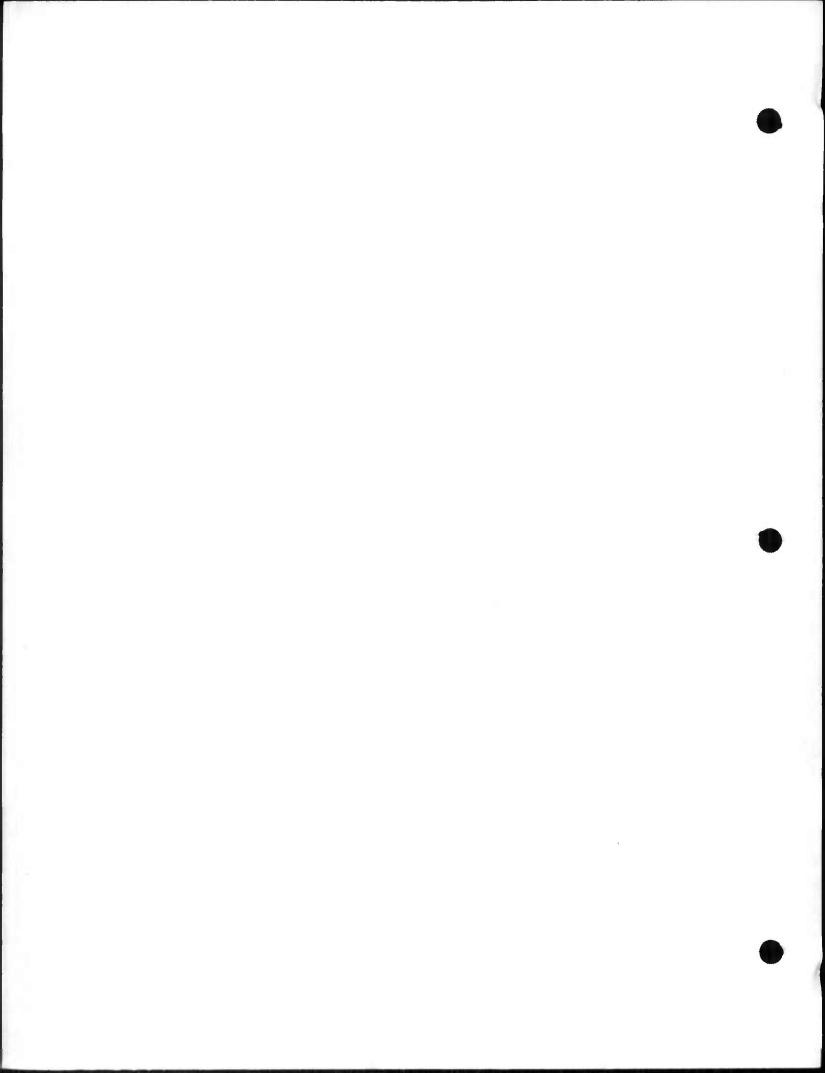
	FOR 1 - STATE REGISTRAR	STATE OF MARYLAN	D / DEPARTI			MENTAL HYG			
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEAT	Н	3. TIME OF DEATN	
	RENEE	P	ALMANO			OCT.	22, 1995	11:34 A M	
	4. SOCIAL SECURITY NUMBER 5.	SEX 6. AGE (In y	- //	F UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTI	N 0.	BIRTNPLACE (State or Foreign Country)	
	213-13-0073		9 YRS.	ONTHS DAYS	HOURS MIN.	Oct 1,	1976	MD	
œ	9e. FACILITY NAME (If not institution, give street	. 9		R LOCATION OF DE		9c. COUNTY			
DIRECTOR	CALVERT MEMORIA				ce FRede	rick	CA	LVERT	
RE	10a. STATE 10b. COUNTY			TOWN OR LOCAT	ION			10d. INSIDE CITY LIMITS?	
		vert	Ow	vings				1 TYES 2 X NO	
FUNERAL	10s. STREET AND NUMBER			101.	ZIP CODE		27.00	OF WHAT COUNTRY?	
NE I	8940 Sherbrook Ct	. WAS DECEDENT EVER IN U.	S ARMED	13 WAS DEC	20736 ENDENT OF NISPAN	IC OBIGIN2 (Specie		U.S.A.	
	1 X Never Merried 2 Merried	FORCES? 1 YES 2	≥ X NO	It yes, spe	city Cuban, Mexicer 2 X NO Specity	, Puerto Ricen, etc		Bleck, White, etc.	
ВУ	3 Widowed 4 Divorced	W YES, GIVE WAIT ON ONLE		1 143	z gg NO Specify			specify: white	
COMPLETED	15. DECEDENT'S EDUCATI (Specify only highest grade con		ia. DECEDENT'S US (Give kind of wor	rk done during mo:		16b. KIND O	F BUSINESS/INDUS	TRY	
۳	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT use	udent.			0-11		
M	17. FATNER'S NAME (First, Middle, Last)		50	udent	16. MOTHER'S NAI	AF (Flora Adiodolo Ad	College		
	Richard Santo Pa	almano				er Rinda			
BE	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING A	DDRESS (Street e	nd Number or Rural F			rda)	
임	Esther Bailey			herbro		wings,			
	200. METNOD OF DISPOSITION	20b. Pt	ACEAND DATEOF	DISPOSITION (Na	me of		c. LOCATION — CIT		
	1 X Buriel 2 ☐ Cremetion 3 ☐ Removal 4 ☐ Donation 5 ☐ Other (Specify)	Sc	outhern I	Mem. Gr	dns 10-2	25-95 E	unkirk,	MD	
- 1	21. SIGNATURE OF FUNERAL SERVICE LICENS	4 11		22. NAME AN	ID ADDRESS OF FAC	CILITY			
	2/aug M	Loll		Rausch	Funeral	Home.	PA Owin	gs, MD 20736	
	25. PART I. Enter the Meases, or com shock, or heart failure. List	plications that coused th	ne death. Do no					t, Approximata	
7	IMMEDIATE CAUSE-(Final	7	T HEIG.					Interval Batween Onset and Death	
	diseese or condition resulting in death)	ACUTE NARCOT	IC AND CO	CAINE INT	OXICATION				
		DUE TO (OR AS A CO	ONSEQUENCE OF):						
8	Sequentielly list conditions, b								
CERTIFICATION	if any, leading to immediate cause. Enter UNDERLYING	diete							
FIC	CAUSE (Diseese or injury that initiated events	DUE TO (OR AS A CO	ONSEQUENCE OF):						
F	reaulting in death) LAST								
	PART il. Other algnificant conditiona c	ontributing to death but	not resulting in	the underlying	cause given in	Part i 24a W	AS AN AUTOPSY	24b. WERE AUTOPSY FINDINGS	
CAL		online to goath but	not resulting in	the underlying	g cause given in	PE	RFORMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE	
MEDIC						¹ □ Y	ES 2 NO	OF DEATH?	
≥	DID TOBACCO USE CONTRIB	SUTE TO CAUSE OF	DEATH YES	ПИОГ	UNCERTAIN	<u>-</u>		1 YES 2 NO	
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL		PLACE OF DEATH						
Sic		OSPITAL: Inpetient 2X ER/Outpetie		OTHER:	e 5 🗆 Residence	6 Other (Specifi	v)		
F	27. MANNER OF DEATN	28e. DATE OF INJURY (Month, Day, Year)	FOUND	OF 28c. INJ	URY AT	26d. DESCRIBE	OW INJURY OCCU	RED	
ВУ	1 Netural 5 Pending 2 Accident Investigation	FOUND 10-22-9	5 9:05	A ^M 1	res 2 XXNO	UNKNOWN			
_ 1	3 Suicide 6 XXCould not be	26a. PLACE OF INJURY — building, etc. (Specify)	At home, term, str	eet, fectory, offic	•	26t. LOCATION (S City or Town,	State) 8940 S	HERBROOKE"COURT	
E			JUNU AT HU	ME		OWINGS,	MARYLAND		
COMPLETED	onel	N: To the best of my knowled On the basis of exemination e						cause(s) end menner es stated.	
	296. SIGNATURE AND TITLE OF CERTIFIER	1 00			29c. LICENSE NUM	IBER	29d. DATE SIGNED (Month, Day, War)		
O BE	Dennis	, Christe mi)		00	ME	▶ 00	CT.23,1995	
임	30. NAME AND ADDRESS OF PERSON WHO C		N (ITEM 27) (Type, F	Print)					
	DENNIS CHUTE			nn Str	eet, Ba	ltimor	e, Mary	land 21201	
	31. DATE FILED (Month, Day, Year) 0.7.7 2.6 1005	32. REGISTRAR'S SIGNATI							



FOR 1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CE	ERTIF	ICATE OF	DEATH	R	EG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last)		11 12				2. DATE OF I	DEATH		WE4.5	3. TIME OF DEATH	
	George B. P	yle Jr.					10.11	200	27	95	1350	M
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. les	t birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF E (Month, De	HTRIE	71/	8. BIRTH	PLACE (State or Foreign	_
	212-38-0600	1 XM 2 F	56	YRS.	MONTHS DAYS	HOURS MIN.	Dec 2	1938	}	Mary		
	9e. FACILITY NAME (If not institution, give s	treet and number)		9b. CITY, TOWN	OR LOCATION OF D	EATH		9c. COU	NTY OF D	EATH	_	
6	Union Hospital				E1kton				Ce	cil		
<u> </u>	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNT	v -		100 017	Y, TOWN DR LOCA							
DIRECTOR	MD Cec										10d. INSIDE CITY LIMITS?	
	10s. STREET AND NUMBER	YT		CI	nesapeak	. ZIP CODE					1 YES 2 ND	
FUNERAL	510 Short Cut R	d			10	21915			11116		WHAT COUNTRY?	
Ž	11. MARITAL STATUS	12. WAS DECEDENT	EVED IN HE AD	MED	40 1100 000	ENDENT OF HISPA			USA			
	1 Never Married 2 A Merried	FORCES? 1 [IF YES, GIVE WA	XYES 2 N	10	If yes, sp	ecify Cuben, Mexica	en, Puerto Ricar	pecity Yes i, etc.)	or No-	Black	— American Indian, , White, etc.	
B≺	3 Widowed 4 Divorced		tnam Er	a	1 U YES	2 X NO Specif	ly:			Specifi Whi		
8	15. DECEDENT'S EDU (Specify only highest grade	CATION	16a. DE	CEDENT'S	USUAL OCCUPATION	ON	16b. KIN	D OF BUS	INESS/INC		-	-
9	Elementary/Secondary (0-12)	College (1-4 or 5 +)			vork done during mo e retired.)	ist of working						
MP	12		Ma	il Ca	arrier		Po	stal	Serv	vice		
COMPLETED	17. FATHER'S NAME (First, Middle, Last)					18. MOTHER'S NA		.,				
BE	George B Pyle Sr	•					ce Bla					
6	19e, INFORMANT'S NAME (Type/Print)		19t	MAJLING	ADDRESS (Street a	and Number or Aural	Route Number, C	ity or Town	, State, Zic			
- 1	Peggy Pyle))	10 Si	nort Cut	Rd Ches	apeake	Cit	y MD	219	915	
	20a, METHOD OF DISPOSITION 1 Burlel 2 Cremetion 3 Rem	oval from State	20b. PLACE A	ND DATE C	F DISPOSITION (Ne	nme of	OATE			City or Tox		
	4 Donalion 5 Other (Specify)	PENGER	Bethe	:I Ce	metery			Che	sape	ake	City MD	
1	0 11	ENSE				Foard F		Home	o D	٨		
	Mariet 1 =	la col			POB	ox 27 Ch	esapeal	ke C:	ity N	MD 2	21915	
	23. PART I. Enter the diseases, or can shock, or heart failure.	complications that	caused the de	ath. Do n	ot enter the mo	de of dying, suc	h as cardiac	or respir	atory an	reat,	Approximata	
	IMMEDIATE CAUSE (Final	List Only Dila Caus	B Dit allen lina.								Onset and Dea	
	disease or condition resulting in death)		JOK)							3-0cm	19
- 1		DUE TO (C	AS A CONSED	UENCE OF):						-	4
8	Sequentially flat conditions,	· H			30021	NC					10443	>
CERTIFICATION	if any, leading to immediate cause. Enter UNDERLYING	OUE TO (C	ASTA CONSEC	UENCE OF):						7	
윤	CAUSE (Disease or injury that initiated events	DUE TO (O	R AS A CONSEC	DENCE OF	Y						Syrs	4
E	resulting in death) LAST	0	hor			rhy	HALL	CI			29	,
			X1CX								12000	4
EDICAL	PART II. Other significant condition	s contributing to d	eath but not re	suiting i	n tha underlying	cause given in	Part I. 24a.	WAS AN A		24b.	WERE AUTOPSY FINDING	S
ä							1	YES 2			COMPLETION OF CAUSE OF DEATH?	
ME							_				1 YES 2 NO	
ä	DID TOBACCO USE CONTI	RIBUTE TO CAU	SE OF DEAT	TH YE	S NO	UNCERTAI	N					
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLAC	E OF DEAT	H (Check only one)							
YSI	1 YES 2 NAO	1 Vinpatient 2 🗆 E	R/Outpatient 3	□ DOA	OTHER: 4 Nursing Hom	e 5 🗆 Residence	6 🗆 Other (Spe	ecify)				
표	27. MANNER OF DEATH 1 Netural 5 ☐ Pending	28e. DATE DF IN (Month, Day,	IJURY Year)	28b. TIME		URY AT RK?	28d. DESCRIB	E HOW IN	JURY OCC	CURED		
B≼	2 Accident Investigation					ES 2 NO						
	3 Suicide 6 Could not be 4 Homicide determined	26e. PLACE DF building, et	INJURY — Al hor c. (Specify)	ne, farm, si	treet, factory, office	•	261, LOCATION City or Tox	N (Street er	nd Number	or Rural Re	oute Number,	
Ē.	201 05000000											
릴	290. CERTIFIER (Check only one)	CIAN: To the best of m	y knowledge, dea	th occurre	d at the time, date	end place, and due	lo lhe cause(e)	end men	ver as stat	ed.		
COMPLETED	MEDICAL EXAMINE	0 0	nination end/or in	vestigation	n, in my opinion, d	eath occured at the	time, date end	place, end	due to th	e cause(e)	and menner as stated.	
B (29b. SIGNATURE AND TITLE OF CERTIFIES	11/10	1			29c. LICENSE NUN	MBER		29d. DAT	E SIGNED	(Month, Day, Year)	\exists
0 1	1000//	11/6	$VV \cup V$	/		D447	16		1 (a)	2+-	27 1995	
-	30. NAME AND ADDRESS OF PERSON WHI	COMPLETEO CAUSE	OF DEATH (ITEM	27) (Туре,	Print)			1			nd 2 1921	7
	JOSE///A. M.J) 111 W	· Nigi	5	t. Qui	HE 20	4 /	=1K	70N	1	nd 21921	
	31. DATE FILED (Month, Day, Year)						,					
	OCT 3 0 1995 A	il Studen	nardall									

DHMH-16 Rev 1/89



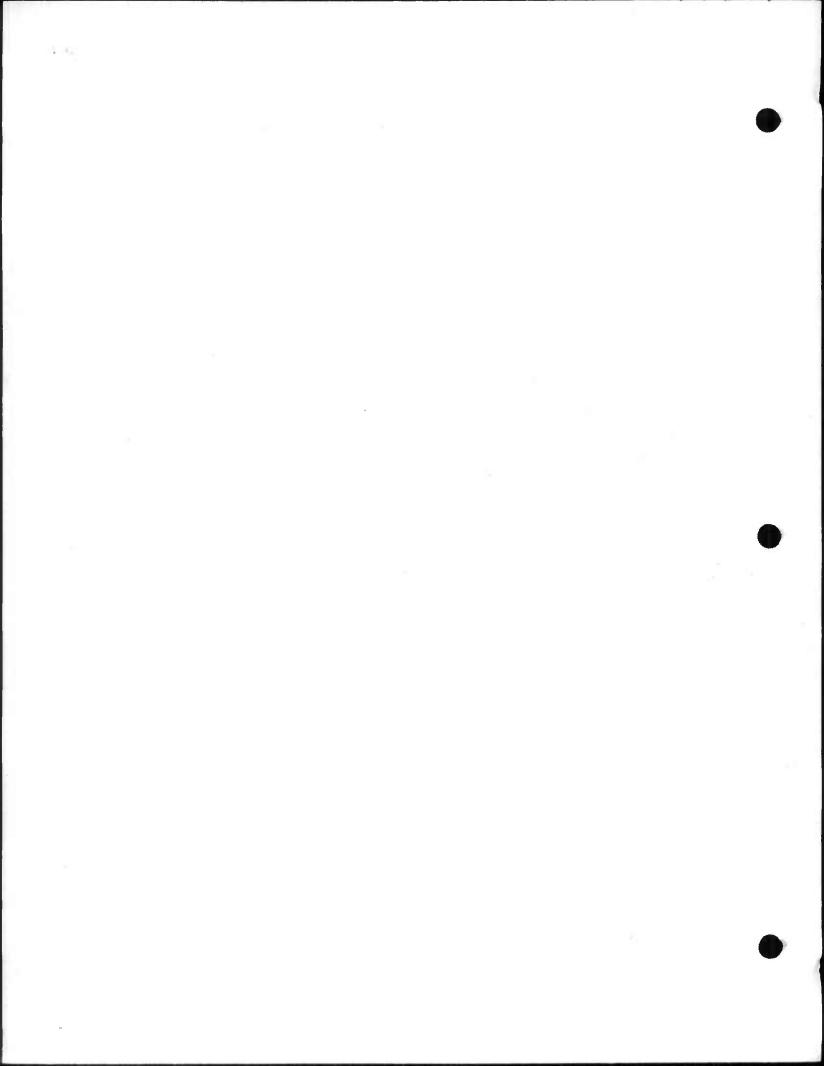
1 - STATE REGISTRAR

	FOR STATE REGISTRAR		STATE C		CERTII	FICATE O	F DEATH		REG. NO.			
	1. DECEDENT'S NAME (First	et, Miciolie, Las	o()					2. DAT	E OF DEATH		YEAR	3. TIME OF DEAT
	Micha		E		Petrel					21.199		4:00
	4. SOCIAL SECURITY NUM		5. SEX		(In yrs. lest birthday	MONTHS BAYE		7. DAT	E OF BIRTH nth, Day, Year)		Country	PLACE (State or For
	217-84-821 9a. FACILITY NAME (# not i		1 M 2		32 YRS.				3, 19		Wash	nington
				W)			OR LOCATION OF D			9c. COUNT		
	12 St. E	CEDENT	ourt			Co	ckeysvill	e		∐ Ba⊥t	imo	re Coun
RE	Manage I am I	10b. COU				TY, TOWN OR LOC						10d. INSIDE CITY LIMITS?
- DIR	Maryland		timore			ockeysv						1 - YES 2 X
RAL	100. STREET AND NUMBER		r+ #102				101. ZIP CODE					HAT COUNTRY?
FUNE	11. MARITAL STATUS			EDENT EVER II	NUS ARMED	13 WAS D	ECENDENT OF HISPA	NIC OBIO	mm man Man			States
	1 Never Married 2		FORCES?	1 YES	2 NO	If yes,	specify Cubert, Mexico	in, Puerte		or No-	Black,	- American India , White, etc.
ВУ	3 Widowed 4 Div	rorced					TANO Specia	у.		- 1	Specifi	ite
TED		CEDENT'S E	DUCATION ade completed)		(Give kind or	S USUAL OCCUPA work done during i		16	b. KIND OF BUS	SINESS/INDUS		
PLET	Elementary/Secondary ((0-12)	College (1-4	or 5 +)	life. Do NOT				_			
COMPI	12 17. FATHER'S NAME (First, A	Widdle, Lest)	4		Comput	er Soft		ARE Office	Comput		Busi	ness
ECC		Petre	lla				Coppie					
0	19e. INFORMANT'S NAME (19b. MAILIN	G ADDRESS (Stree	Connie				ode)	
2	Mr. & Mrs. 1	Emanu	el Petre	ella			ill Road,					
	20s. METHOD OF DISPOSIT		amoval from Stat	206	PLACE AND DATE	OF DISPOSITION	Name of Oct 2	5 PC	76 E 20c. LO	CATION - CIT	y or Tow	
	4 Donation 8 Donat	r (Specify)		St	metery, cremetory or Mary	s Churc	1 Cemeter	371	11011	port,		
	21. SIGNATURE OF FUNERA	AL SERVICE	LICENSEE			22. NAME	AND ADDRESS OF FA	CILITYT	ee Fun	oral E		T 66
			//					Τ.	ree run	crar I	Iome	, inc 66.
	23. PART I. Enter the canada shock, pri	diseases, o	or complications a. List only ons	that ceused	the death. Do	OTG 1	Alexandri	a Fe	erry Ro	ad, Cl	int	on, MD 2
	23. PART I. Enter the c	diseases, o haart fallur	a. List Dnly Dna	cause on a	ach lina.	OTG 1	ALEXANDRI	a Fe	erry Ro	ad, Cl	int	on, MD 2
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DIVISION OF VITAL RECORDS, P.O. BOX 68760

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BHYSIC	er this certi	th with th	payar
THE HOSPITAL OR ATTENDING PHYSICIAN	IRECTOR: After this	e filed within 72 hours after death	MDORTANT if item 28 is marked or item 22 shows any injury or other traumotic areas the marked or item 22 shows any injury or other traumotic areas the marked or item.
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	1 - FOR STATE REGISTRAR	STATE OF MARYL		RTMENT OF I		MENTAL HYGIEN					
	1. OECEDENT'S NAME (First, Middle, Last)	Mildred Ma	y Paule	у		2. DATE OF DEATH MONTH OCt. 24		3. TIME OF DEATH 11:45 A. M			
	4. SOCIAL SECURITY NUMBER 213-01-5879	5. SEX 6. AGE (1	In yrs. lest birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Feb. 23,		B BIRTHRI ACE (State or Section			
OR	9a. FACILITY NAME (II not institution, give at Meredian Nursir				ederick		-	UNITY OF DEATH Frederick			
DIRECTOR	10e. STATE 10b. COUNTY	ontgomery	10c. CIT	y, town or Local			10d, INSIDE CITY LIMITS?				
FUNERAL (10e. STREET AND NUMBER	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			20874		10g. cm	1 TIZEN OF WHAT COUNTRY?			
BY FUNE	18240 Metz Rd. 11. MARITAL STATUS 1 Never Married 2 Merried 3 M Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2X NO	If yes, sp	ENDENT OF HISPA	NIC ORIGIN? (Specify Year, Puerto Rican, atc.)		14. RACE — American Indian, Black, White, etc.			
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	16a. DECEDENT'S (Give kind of life. Do NOT us		DN st of working	federal		rernment			
BE COM	17. FATHER'S NAME (First, Middle, Last) RUSSELL C. V		decod	Tearre		ME (First, Middle, Meider se Stone					
TOE	190. INFORMANT'S NAME (Type/Print) Robert C. Bass		19b. MAILING	ADDRESS (Street of Brookshi	re Run,	Pt. of Roc	cks,	Md. 21777			
	1 2 Buriel 2 Cremation 3 Remo	20a. METHOD OF DISPOSITION 10X Burles 2 Cremation 3 Removed from State 4 Donation 6 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of carried part									
	21. BIGHATURE OF FUNERAL SERVICE LIĞ	Morte		Donald B. Thompson Funeral Home 31 E. Main St., Middletown, Md. 21769							
	IMMEDIATE CAUSE (Fine)	ist only one cause on ea	anemine.	not enter the mo							
ERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST										
MEDICAL C	PART II. Other algnificent conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. Chronic obstructive pulmonary austase. 1 YES 2 NO 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?										
	DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL EXAMINER?			S NO C	UNCERTAI	N 🗆		1 YES 2 NO			
PHYSICIAN:	1 YES 2 NO	HOSPITAL: 1 Inpatient 2 ER/Outpa 288. OATE OF INJURY	28b. TIM	E OF 28c. INJ	URY AT	6 Other (Specify) 28d. OESCRIBE HOW	INJURY OC	CURED			
D BY P	1 Netural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	(Month, Day, Year) 28a. PLACE OF INJURY	- At home, ferm,	M 1 🗆 1	RK? /ES 2 NO			er Or Rural Route Number,			
ETE	4 Homicide determined	building, atc. (Speci	17/)			City or Town, State)				
COMPL		CIAN: To the best of my knowle t: On the bests of examination						ited. the cause(e) and manner as stated.			
TO BE	29b. SIGNATURE AND TITLE OF CERTIFIER ACHILLEV O AND NAME AND ADDRESS OF PERSON WHO	Stein MO			D320) 73	29d. DAT	TE SIGNED (Month, Day, Year)			
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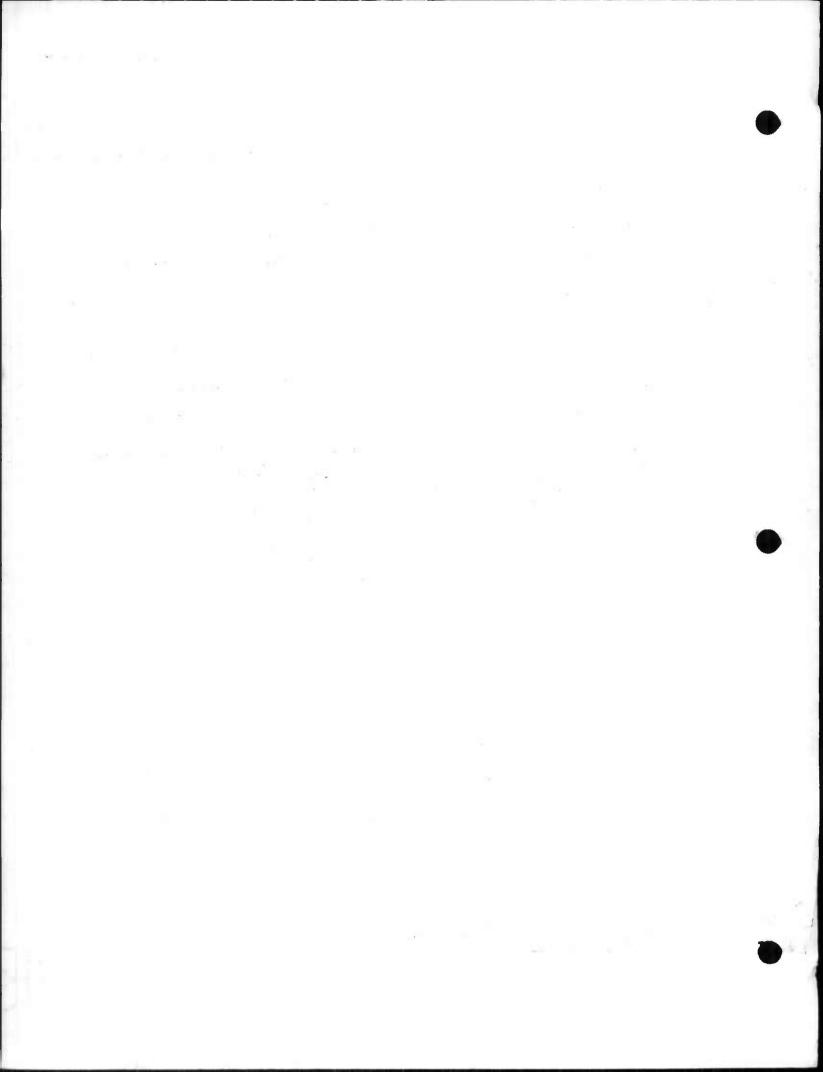
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DIVISION OF VITAL RECORDS, P.O. BOX 68760	L DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the nour after death. Page 6 may be retained by the hospital or attending physician.	L DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit page.	hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

ormit. Pages 1, 2, 3 should / 0 TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the hours after death. Page 6 may be retained by the hors TO THE FUNERAL DIRECTOR. After this cardificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached to filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: It liem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

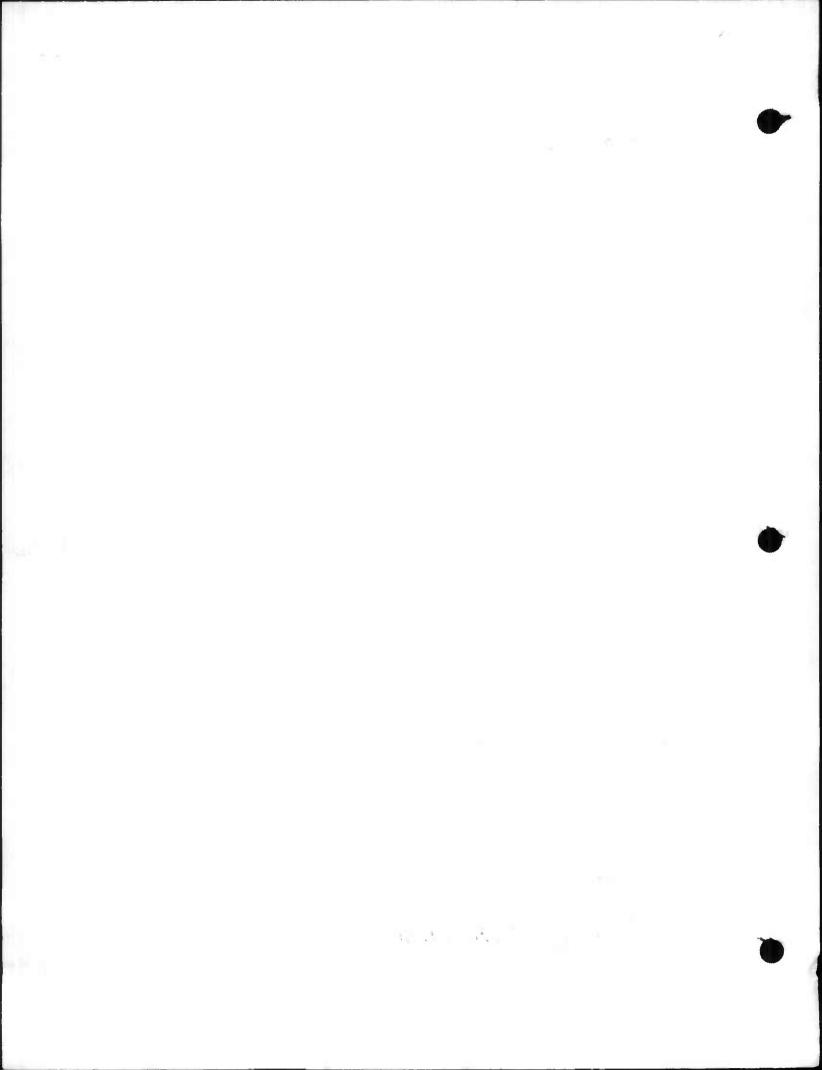
E	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL	HYGIENE
STRAR	CERTIFICATE OF DEATH	REG. NO.

	1 - STATE REGISTRAR	STATE OF MA	ARYLAND / DEPAR	TMENT OF H		MENTAL HYGIS					
	1. DECEDENT'S NAME (First, Mide	dia, Last)				2. DATE OF DEATH MONTH	DAY	YEAR 3. TIME OF DEATH			
	4. SOCIAL SECURITY NUMBER	5. SEX 8	AGE (In yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	I. BIRTHPLACE (State or Foreign				
	579-40-7169	1 M 2 🔀 F	85 YRS.	MONTHS DAYS	HOURS MIN.	May 10,	1910 K	ingston, Jam.			
œ	90. FACILITY NAME (If not institute Washington A	ion, give street and number) Adventist Hosp	ital		OR LOCATION OF D		Y OF DEATH				
6	RESIDENCE OF DECED		Ital	Tako	ma Park,	Mon	ontgomery				
DIRECTOR		county Prince Georges		y, TOWN OR LOCA restvil		land		10d. INSIDE CITY LIMITS? 1 X YES 2 NO			
FUNERAL	100. STREET AND NUMBER 2100 Brooks	Drive #211	10	10f. ZIP CODE 20747			ed States				
BY FUN	11. MARITAL STATUS 1 Never Merried 2 Merr 3 Widowed 4 Divorced	12. WAS DECEDENT B FORCES? 1 FYES, OIVE WAR	If yes, sp	ENDENT OF NISPA ecify Cuben, Mexic 2 NO Speci	NIC ORIGIN? (Specify en, Puerto Rican, atc.) fy:	Yes or No- 1	4. RACE — American Indian, Black, White, etc. Specify: Black				
COMPLETED	15, DECEDEN (Specify only high Elementary/Secondary (0-12)	AT'S EDUCATION nest grade completed) College (1-4 or 5 +)	16a. DECEDENT'S (Give kind of life. Do NOT u	USUAL OCCUPATION Work done during more retired.)	ON st of working	16b. KIND OF	F BUSINESS/INDUSTRY				
MP	12		Hous	e Keeper							
	17. FATHER'S NAME (First, Middle, John Sterlin	*			- 10 20 10	AME (First, Middle, Maid					
BE	190. INFORMANT'S NAME (Type/P	<u> </u>	Less manuel			ebecca Sterling					
2	Patricia Po		2100	Brooks	(Street end Number or Pural Route Number, City or Town, State, Zip Code) Oks Drive #211 Forestville, MD 20747						
	STATE OF DISPOSITION 1 District 2 Cremetion 3 4 Departies 5 Other /Spec		of disposition (Ne the Memoria	1 Park	Land	City or Town, State					
n. monature of Funeral Bervice Licenses 22. NAME AND ADDRESS OF FACILITY Pope 5538 Marlboro Pike							neral	Homes			
ALION	23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory streat, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Approximats interval Betwee Onset and Death of the cause of th										
CERTIFICATION											
PHYSICIAN: MEDICAL	PART ii. Other algorificent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 TYES 2 N NO										
ž	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN										
5	25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)										
2	1 YES 2 NO	YES 2 NO 1 □ Inpetient 2 M ER/Outpetient 3 □ DOA 4 □ Nursing Home 5 □ Residence 8 □ Other (Specify)									
	1 Natural 5 Pend		Year) IN.	URY WO	URY AT RK? 'ES 2 NO	RED					
0	2 Cutalda	28e. PLACE OF II	NJURY — At home, ferm,				N/A ATION (Street and Number or Rural Route Number,				
building, etc. (Specify) Specify								State)			
COMPLEIED	29e. CERTIFIER (Check only 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner es atated.										
	one) 2 MEDICAL EXAMINER: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date end piece, end due to the cause(a) e 29b. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED //M										
	m-so	roche	UMBER 29d. DATE SIGNED (Month, Day, Year) \$74 10-23-95								
	30. NAME AND ADDRESS OF PER	SON WHO COMPLETED CAUSE	0F OEATH (ITEM 27) (Type) 717 - 38 4	Print)	TAGE C	(14),	ND 20	722			
	31. DATE FUCMONIA, 27760	95 July Will	SIGNATURE CALL								



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	4. SOCIAL SECURITY NUMBER			5. SEX 6. AGE (In yrs. lest birth			t birthday)	IF UNDER	L YEAR	IF UNDER	24 HRS.	O C	OF BIRTH	1	93	STHE AC	E (State or Formio
	225-54-359	96	1 🗓 N	1 2 🗌 F	56		YRS. MONTHS DA		DAYS			(Mon	h, Day, Year)	1020	Co	untry)	
	9a. FACILITY NAME (If not	t institution, g	live street and				9b. CITY, TOWN OR LOCATION OF DE			Aug. 8, 1939 Vin			11a				
СТОЯ	Holy Cross	s Hos	pital					Silver Spring Montgomery Co									
ح	RESIDENCE OF DE	10b. COL	T								II Z			Mon	Lgo		
DIRE	Maryland				1_			CITY, TOWN OR LOCATION								222	INSIDE CITY LIMITS?
	100. STREET AND NUMBE		nce Ge	orge			Le	Lewisdale 101, ZIP CODE					10g. CITIZEN OF				YES 2 💢 NO
FUNERAL	2013 Avalo	on P1:	ace					20783 United									
	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S					U.S. ARI							_		merican Indian.		
	IE VES				ES? 1 YES 2 NO				If yes, specify Cuban, Mexican, Puerto			rio Rican, etc.) Blac		ack, Whi	ta, etc.		
D BY	3 Widowed 4 Divorced				, are wall on sales					opeany				3.		ack	
W	15. DECEDENT'S EDUCATION (Specify only highest grade compile)			npleted) (Give kind			ve kind of	work done	CCUPATIO	ON ost of working	g	168	KIND OF B	JSINESS/IN	DUSTRY		
COMPLET	Elementary/Secondary (0-12) Co		Colleg	College (1-4 or 5+j				re kind of work done during most of working Do NOT use retired.)					Federal Government				
N N	17. FATHER'S NAME (First,	Middle Leet	1 2			Supervisor					IPPIO 111				CIII	acii (
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BE	Witcher Parker					19h	, MAILING	ADORES	S (Street -		lvin		Ler ber, City or To	em Chair Ti	in Cart		
5		Eva Odessa Parker														20	792
	20a, METHOD OF DISPOS	ITION		12	20b. I	PLACEA	NODATE	Avalon Place, Lewisdale, Maryland 20783 EOF DISPOSITION (Name of april 20c, LOCATION — City of Town, State									
	20a. METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 X Removal from State 4 Donation 5 Other (Specify) Flora Hills Garden Cem. 10/22/95 Danville, Virginity									rinia							
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY										SINIA						
	Fort Lincoln Funeral Home, Inc. 3401 Bladensburg Rd., Brentwood, MD 20722																
	23. PART i. Enter the shock, pr iMMEDIATE CAUSE (F disease or condition resulting in death)	heart fallu	or complication. List price	y one csu	ise on eac	ch line.	لاسا	anot enter	401 the mo	Blade	ensbi	as cer	Rd., I	Brent	WOO	d, M	Approximata interval Betw
HTIFICATION	immediate Cause (F	ditions, nediate.	a	DUE TO	ise on eac	CONSED	DUENCE OF	34 not enter	401 the mo	Blade	ensbi	as cer	Rd., 1	Brent	WOO	d, M	Approximata interval Betw
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NG	fter	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	E
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	FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPART					0 1000		
	1. DECEDENT'S NAME (First, Middle, Last)	y	Patter.		DEATH	2. DATE OF DEATH DOWN DOWN DOWN DOWN DOWN DOWN DOWN DOWN		3. TIME OF DEATH 230 A M		
	4. SOCIAL SECURITY NUMBER 227-34-3824 90. FACILITY NAME (If not institution, give stre	1X M 2 🗆 F	63 YRS.	F UNDER 1 YEAR IONTHS DAYS	IF UNDER 24 HRS. HOURS MIN. OR LOCATION OF DE	March 20, 1932 Washington, DC				
CTOR	Laurel Regional Ho	Benvece,		L	aurel	AIN	Prince George's			
DIRECTOR	Maryland Prince	e George's		town on Local			10d. INSIDE CITY LIMITS? 1 X YES 2 NO			
FUNERAL	15021 Cherrywood I	Drive 12. WAS DECEDENT EVER IN	ILE ADMED		20707		of what country?			
B	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 X YES IF YES, GIVE WAR OR DAT	2 NO	If yes, s		IIC ORIGIN? (Specify Yes n, Puerto Rican, atc.)	s or No 14.	RACE — American Indian, Black, White, etc. Specify: Black		
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use refired.) 16b. KIND OF BUSINESS/INDUSTRY							TRY		
	4 Retired Teacher D. C. Government 17. FATHER'S NAME (First, Middle, Lest) 18. MOTHER'S NAME (First, Middle, Malden Surneme)									
TO BE	Walter Patterson Georgia Conyers 190. INFORMANT'S NAME (Type/Print) 190. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)									
	James Marsh 807 Woodglen Place, Pikesville, MD 21208 20a. METHOD OF DISPOSITION Commetten 3 Removal from State 4 Donation 5 Other (Specify) Maryland National Memorial Park Removal from State Maryland National Memorial Park Laurel, Maryland									
	21. SIGNATURE OF WHERAL SERVICE LICE		- ylana iva	STEWA	ND ADDRESS OF FA	L HOME		ngton, D. C.		
	23. (aff I. Enter the diseases, or constant shock, Dr. heart fellure. L. IMMEDIATE CAUSE (Finel disease or condition resulting in death)	Atems soler	ch ilne.	t enter the m	ode of dying, suc	h ss cardisc or reap	iratory arrest			
CERTIFICATION	Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):									
CERT	resulting in death) LAST									
MEDICAL	PART II. Other significent conditions	contributing to deeth bu	it not resulting in	the underlying	ng cause given in	Part I. 24s. WAS AN PERFO	RMED?	24b. WERE AUTOPSY FINDINGS ANAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO		
PHYSICIAN:	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN DESCRIPTION OF DEATH (Check only one) 25. WAS CASE REPERRED TO MEDICAL HOSPITAL: OTHER:									
	1 Netural 5 Pending (Month, Day, Year) INJURY WORK? M 1 YES 2 NO						6 Other (Specify) 26d. DESCRIBE NOW INJURY OCCURED			
TED BY	2 Accident Investigation 3 Suicide 8 Could not be determined 28e. PLACE OF INJURY — At home, farm, atreet, tectory, office City or Town, Stete) 28t. LOCATION (Street and Number or Rural Rounding, etc. (Specify)									
COMPLET	29e. CERTIFIER (Check only one) 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data end place, and due to the cause(s) end menner as attated. 2 MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, end dua to the cause(s) and manner as stated.									
TO BE C	296. SIGNATURE AND TITLE OF CERTIFIER	COMPLETED CASS OF DEA	m		72. LICENSE NUI		OCH D	IGNED (Month, Day, Year)		

DHMH-18 Rev 1/89

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